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Coronary Vascular Heart Disease

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A recent editorial in the *British Medical Journal* discusses the result of the postmortem examination of the heart of the late Sir James Mackenzie. Mackenzie was undoubtedly, in the latter years of his life, the outstanding cardiologist of the English speaking world, if not of the whole world. He had an attack of heart pain in 1908, when fifty-five years old, which came on when he was at rest. This pain was severe and continuous for two hours. He was restless and obtained the most comfort when moving around. He took 10 grains of veronal and then fell asleep. The next day he was entirely well but he did notice that the pain could be brought on by such measures as walking in cold air, or after a full meal. All this case history, incidentally, is described anonymously in his well known book on angina pectoris. It was not until 1922, however, that these attacks of cardiac pain became severe enough to necessitate his cutting down markedly on his activity. As result of the effect of the cold, bleak, windy weather on his heart pain he had to give up his work so auspiciously started at St. Andrews and to return to London. From that time on to his death he had several severe attacks when peaceful and quiet. When he was seventy-two years old, January 25, 1925, he had an extremely severe attack and death occurred the following day without pain.

Now Mackenzie was a man who had studied angina pectoris the greater part of his medical life. Angina pectoris fifteen years ago was almost synonymous with the name of Mackenzie and yet Mackenzie, in his various publications and books, never recognized the association of angina pectoris and coronary closure. He recognized the condition of status anginosus but apparently did not appreciate this continuous heart pain as due to cardiac infarction.

At autopsy it was found the left ventricle was large and thick walled. In the heart muscle were several small whitish patches of fibrous tissue. In the anterior wall there was a patch of fibrous tissue of considerable size with another smaller area in the posterior wall about half way between the apex and the base. At the extreme base there was a recent hemorrhagic infarction. There was extreme thickening of the wall of the coronary vessels and diminution of the lumen. The pathologist who made the examination concludes that Mackenzie undoubtedly suffered from several attacks of closure of the smaller branch of the coronary vessels, the first occurring seventeen years before he expired, and the last just before he died.

History

These notes from the editorial of the *British Medical Journal* are significant. It was one of the peculiar ironies of life that such an outstanding cardiologist, living until only fifteen

years ago, did not recognize coronary occlusion. It also showed that this disease, while undoubtedly of considerable frequency in bygone days, nevertheless was not recognized. Although the clinical syndrome was described by two Russians, Obratzow, and Straschesko in 1910, and in 1912 an American observer, Dr. Herrick, it is the general concept that coronary arterial disease really had its beginning in scientific medicine at this time but this statement applies largely to the clinical recognition of cardiac infarction. These two papers fell like "duds," to quote Dr. Herrick. There was no repercussion until nearly six years later, when a second paper by him aroused the interest of the clinician and cardiologist, probably as a result of the revival of interest in the anatomy and physiology of the heart stimulated by the work of men as His, Tawara, Keith and Gaskell.

At a Frank Billings Lecture delivered by Dr. George Dock, he reviews most carefully and deeply from the time of Heberden to Osler the historical features of coronary closure. Dock points out that there were many pathologists who recognized local fibroid degeneration of the heart muscle and the association with coronary arterial disease. The pathogenic relation of the coronary arteries to heart disease was well understood by the pathologist of fifty years ago. Dock questions why it was that if the pathologists and those at the mortuary table knew the importance of cardiac infarction and its dependence upon coronary disease, why was it not clinically recognized and accurately treated. Dock's historical paper is particularly interesting because he is believed to have been the first man to make the diagnosis, doing this in 1896. However, the importance of his contribution was not recognized either by himself or by the medical profession.

Krehl, the great German clinician, and Huchard, an equally famous Frenchman, in the first part of the present century recognized the association of angina pectoris with coronary occlusion.

To Herrick we are indebted for bringing this condition to the attention of the medical profession. He wrote that the condition could be recognized during life; it was not necessarily fatal; that it was a readily recognized clinical entity and that the symptoms could be analyzed so that differentiation could be made between angina pectoris and this present condition I am discussing.

Among the names of those who have been interested in this syndrome should not be forgotten the name of Libman who, in 1919, stressed the importance of pericardial friction rub and leukocytosis as diagnostic findings of great value.

Lastly, it is appropriate that I should mention the book, edited and written in part by Robert L. Levy, on "Diseases of the Coronary Arteries and Cardiac Pain." This book, of some 400 pages, was compiled by the editor working with a group of well known cardiologists, physiologists and anatomists. It is most complete and of inestimable value.

In order that one should not think that the subject is largely a disease in which the American clinicians are primarily interested, I might state that in my library I have a series of monographs prepared by Guillermo A. Bosco of Buenos Aires which is a tome of some 755 pages and to which he is continually adding. Just within the last few months I have received a fourth and a fifth part of this book containing respectively 183 and 140 pages, indicating that South American physicians are likewise taking a lively interest in this very important disorder of the heart.

Etiology

Coronary occlusion may occur in almost any age period, in the old individual it may be expected; in a young person however, the occurrence of this condition is quite unusual. Jamison and Hauser[8] reported an instance in New Orleans of a very young man which was confirmed by autopsy. Levine,[9] in his paper which appeared in *Medical Monographs,* discovered only three of 145 people in whom the disease developed under forty years of age. A. Stuart Ferguson and Lockwood,[4] in a review of the literature of this condition as it occurs in young people, in turn report a patient who recovered who was only twenty-six years of age. However, merely because a person is young is no reason why the syndrome should not be diagnosed if it is classical in character, otherwise there is no doubt but that it will probably be overlooked.

One of the most comprehensive statistical studies made on this condition is a paper by Master, Dack and Jaffe[13] who report upon the age, sex and hypertension in a group of 500

patients. In this group the youngest was aged twenty-seven, the oldest eighty-seven. The average age at the time of the first attack was 54 and the first attack occurred most commonly in the sixth decade of life. In the several age groups the order of frequency was as follows: 26 per cent in those in the seventh decade, 25 per cent in the fifth decade, 33.7 per cent in the sixth decade, under forty years of age, 10 per cent, and over seventy-nine, 5.4 per cent.

Sex

The sexual difference is marked. The males are very much more frequently attacked than females. Parkinson[14] states that 93 per cent of his patients were men. Statistics collected by the Metropolitan Life Insurance Company show a rate in males of 16 per 100,000 as contrasted with 3.5 among women. In Master, Dack and Jaffe's paper 77.4 per cent were men, 22.6 per cent were women. Every clinician knows that it is the man who is more frequently attacked than the female but among those who have a fairly large female clientele the incidence would seem to be higher than these statistics would imply.

Occupation

Occupation is apparently an extremely important predisposing factor. The general concept is that the disease is largely one which is particularly likely to attack those of the upper income group, business and professional men in other words. This contention may be substantiated by the large number of doctors whose deaths are recorded yearly, as I will mention later, who died as result of coronary occlusion. On the other hand, Levy[10] denies this implication and in his over 2,500 necropsy studies it was found that foremen and skilled workers showed 44 per cent coronary lesions, whereas among executives and members of professions the percentage was 34.3, with manual laborers slightly under these figures. Despite this statistical observation, when the physician glances at the obituary columns of the *Journal of the American Medical Association* he is astounded at the number of deaths that occur in the medical profession as result of coronary occlusion or infarction. It has become the commonest cause of death among doctors. A recent editorial[3] in the *Journal,* discussing the obituary of physicians who died the preceding year and summarizing the cause of death, points out that heart disease is the leading cause of death of physicians; for example, 1,585 heart deaths as contrasted with the next most frequent cause, namely arteriosclerosis with 453 deaths, followed by pneumonia with 370 and cancer with 357. It should be noted that when the figures for heart disease are broken down, coronary arterial disease, either thrombosis, occlusion or angina pectoris, resulted in the death of 676 physicians or more than any other one cause of death. Probably this number would be increased considerably were there given an exact cause of death, because "myocarditis" which in the ultimate analysis is usually due to coronary disease, caused 534 deaths. Then there was a group of cases which were labeled as "other diseases of the heart."

Heredity

To my mind in so far as predisposing factors other than age and sex are concerned, heredity ranks first. Whether the constitutional make up is responsible for the marked hereditary tendencies in this disease, many patients are overweight which in turn in many instances is an inheritable characteristic, or whether it is some peculiar arrangement of the coronary vessels which may predispose them to strain, is a debatable question. Dublin believes that if there is any relationship between heredity and coronary disease it is based upon overweight because in people who die of angina pectoris, which of course often is coronary disease, the death rate was twice that of those who had normal weight, two and a half times more frequent than in those who were underweight.

Chronic Disease

Diabetes.—I will not comment upon diabetes except to call attention to the fact frequently reiterated and repeated, that arterial disease anywhere in the vascular tree is common in the diabetic individual, so that it is natural to expect the coronary vessels would not escape the general vascular involvement. Furthermore, these people are often a more advanced age group.

Hypertension.—The question of hypertension has agitated medical men for a long period of time. However, hypertension is by no means a

sine qua non for the diagnosis of the condition. Particularly does this statement apply to men because in the statistics quoted, as compiled by Master et al.,[13] hypertension was noted in only 62 per cent of the cases as occurring in men and in approximately four-fifths of the women. It may be seen that it is definitely higher in women but not necessarily is a relatively low blood pressure unusual in a man who has this condition.

Other Factors.—Other factors such as infections, notably syphilis, the use of alcohol and tobacco or caffein, probably play only a minor rôle in the production of sclerosis of the coronary vessels. The disease syphilis rarely is an etiologic factor of importance; were it so the death rate from this condition, coronary occlusion, would be very much more common than it is among the Negro in whom the syphilitic incidence is high, whereas the coronary occlusion rate is low.

Pathology

Time does not permit a discussion of the pathology in detail. I would like to call attention, however, to a splendid clinical pathologic study made by Blumgart, Schlesinger and Davis[2] which appeared in the January number of the *American Heart Journal*. It is a long, lengthy paper from which I would like to point out one or two important conclusions. It is quite possible for a patient to develop coronary thrombosis and myocardial infarction without any characteristic clinical manifestations. If a gradual occlusion develops over a period of years, during this protracted interval of time there develops an anastomotic circulation, so that all direct symptoms and signs will be absent.

In regard to the pathologic basis for congestive failure, these authors note that certain areas in the heart, undernourished as result of coronary arteriosclerosis, when subjected to greater anoxemia produced by exertion or emotion, develop focal necrosis and diffuse fibrotic changes. This replacement by connective tissue ultimately produces myocardial weakness and finally congestive failure.

The left coronary artery, shortly after its origin from the sinus of the left posterior aortic leaflet, divides into two main divisions, the anterior descending and the circumflex. The anterior descending branch is the artery most frequently involved. As this supplies, as it does, the anterior wall of the right and left ventricle and part of the interventricular septum, it is natural that one of the outstanding physical findings, namely a pericardial friction rub which so often determines definitely the diagnosis, is likely to be produced in some instances in which the area of infarction is sufficiently large to extend out to the parietovisceral pericardium. Likewise involvement of the interventricular septum from time to time will produce heart block, although this complication is relatively rare. Usually it is the right coronary that will bring about this particular condition in 93 per cent of cases, according to Ball.[1] As a matter of fact complete auriculoventricular block from occlusion of the usually involved vessel is apparently rare, as substantiated by a recent paper by Heninger and Dickens.[6]

Symptomatology

It is the general concept that an occlusion of the coronary artery which produces symptoms, is precipitated by some extrinsic factor, be this exercise, excitement, emotion, eating or what not. As was pointed out in a review of the literature by Graybiel[5] "one cannot help being impressed with the fact that many persons with marked coronary atherosclerosis never suffer acute coronary occlusion and cardiac infarction. This being so, there must be precipitating factors of coronary occlusion; the occlusion cannot be regarded as a purely fortuitous event." Be that as it may, every clinician is familiar with the patient who has had his first attack at night during sleep or while completely at rest. If the patient is asleep it might be assumed that a dream of some kind or another may have altered the dynamics of the cardiac circulation to produce the occlusion.

I will not endeavor to recite to you the usual characteristic symptoms of coronary occlusion. They have been dwelt upon so frequently and reiterated so many times that every one is familiar with the syndrome of heart pain, followed by shock, succeeded by fever, leukocytosis and shortness of breath. I would like to point out, however, that pain may be entirely absent or it may be so slight that it escapes the patient's attention. This, of course, is unusual but given an individual who, without cause, may develop

acute dyspnea or pulmonary edema, even if this individual is middle aged, has some slight hypertension and is somewhat overweight but who does not have previously known myocardial or endocardial disease notably of the aortic valves nor does he have marked hypertension, it is quite possible that this patient will have or has had coronary occlusion with infarction. Substernal pain, as pointed out by Herrmann and Decherd,[7] in an analysis of some 230 cases, may be quite atypical. Of the 127 patients in whom the symptom of pain was analyzed, twenty-six of them had atypical substernal pain and quite a group had pain which was referred only to the epigastrium, a well known clinical observation which sometimes still confuses and makes possible the occasional reporting of a death of a patient as being due to "acute indigestion" when it is the result of coronary disease. Pain may be referred to the right shoulder only, to the neck, to the interscapular region or even to the right chest and leg. Of course pain is undoubtedly the most important diagnostic expression of the disease but it must not be forgotten that the condition may develop without even discomfort.

Differential Diagnosis

In this connection in conjunction with the symptom of pain, I would like to point out that the differential diagnosis of the pain of angina pectoris and the pain of coronary occlusion is of extreme importance not only from the prognostic standpoint but also from the viewpoint of the immediate and later care of the patient. It is for this reason that I am presenting a tabulation, as compiled by my associate, W. A. Sodeman, of the important diagnostic points which may help differentiate these two conditions. Incidentally, it will demonstrate also the important diagnostic features connected with the two conditions.

DIFFERENTIAL DIAGNOSIS OF ANGINA PECTORIS AND THE PAIN OF MYOCARDIAL INFARCTION

	Angina Pectoris	*Coronary Thrombosis*
Onset	During exertion	Usually during rest or sleep
Attitude	Immobile	Restive; may walk about
Site of pain	Sternum to arm	Sternum or lower
Duration	Minutes	Hours or days
Dyspnea	Absent	Usually severe
Vomiting	Rare	Common
Shock	Absent	Present
Sweating	Slight	Severe
Facies	Normal	Ashen pallor
Pulse	Unchanged	Feeble, often rapid
Temperature	Unchanged	Subnormal, then febrile
Blood pressure	Unchanged or raised	Lowered
Heart failure	Absent	Often follows
Heart sounds	Unchanged	Gallop rhythm, friction
Leukocytosis	Absent	Present
Electrocardiogram	May be abnormal	Often diagnostic
Action of nitrites	Often relieved	No relief.

Prognosis

Personally I am of the impression that the cumulative data which have to do with the ultimate outcome in coronary occlusion are worthless. I say this advisedly and for several reasons. Statistics that have been compiled have to do with patients who have acute atypical attacks. The experience of all clinicians has been that it is by no means infrequent for people to have mild unrecognized attacks, sometimes discovered accidentally as result of a coronary electrocardiogram. Sometimes these minimal or minor attacks are only recalled by the patient when he has had a major attack and the history is gone into carefully. Undoubtedly there are many patients who do have attacks which are recognized and who continue to go about actively and vigorously. Parenthetically I might remark that Lewis,[11] for example, reported on a patient he had seen some seven years prior to the appearance of this patient and who since that time had done most strenuous activities of all kinds, from flying at altitudes of 15,000 feet to skiing each winter and dancing ad lib. It is possible to generalize to this extent, that the older the patient is the more likely that patient is to succumb and the younger the age of onset the greater is the life expectancy.

Another statistical study, which in this instance has to do with what occurs to the man who has had an acute coronary artery occlusion, is that of Master and Dack.[12] These observers sent out a questionnaire to a series of 415 patients; 185 of whom were private patients and 230 ward patients. The purpose was to determine how much could be done and was being done by a person who had sustained and survived

an acute attack. The authors showed that 53 per cent of patients returned to work after recovering from their occlusion, 57 per cent of whom were private patients and 50 per cent were ward patients. It is of some interest to note that 84 per cent of professional people returned to work and particularly physicians. It is not surprising that age played an important rôle in the ability of the person to resume his usual occupation. As with the prognosis, so in this study it is found that the younger the individual the more likely was he to return to his previous work status. Some of these patients never did stop work, a considerable per cent (48) of them stopped for less than three months. From three to six months was the time period of convalescence from the attack of 22 per cent. One individual did not return to work for six years. Rather interesting that a certain number of the group did not return because they were advised not to, although apparently they were in good condition, and a fairly considerable number, more than those who were physically unable, did not start working because of disability insurance. The chief cause of the inability to return to work was a physical disability resulting either from angina pectoris, dyspnea or from weakness. The concluding paragraph comments to the effect that "an attack of acute coronary occlusion in itself is not sufficient reason for permanent disability. Complete recovery and full or partial economic restitution are common. Heart failure or a severe anginal syndrome is evidence of complete disability." These statements confirm that which is well known and bring further comfort to the man who has had coronary occlusion, that his attack is not necessarily associated with economic dependence.

Treatment

The treatment logically divides itself into three phases: (1) immediate, (2) mediate, and (3) later.

For the immediate treatment the patient should be handled as any patient who has shock—morphine, warmth, absolute quiet but avoiding stimulation. This applies particularly to cardiac stimulants. Be satisfied with giving glucose solution intravenously and letting the glucose act as a maintainer of cardiac reserve. Avoid digitalis and its products unless it looks as if the patient is going to die of heart failure, under which circumstance make use of ouabain. In giving the sugar solution give it by mouth, approximately 1,200 c.c. in twenty-four hours. If it is absolutely essential to give fluid into the vein, then inject not more than 100 c.c. of 50 per cent glucose. Very generally there has come into use a drug, quinidine, in order to prevent the fatal complication of ventricular fibrillation; give 5 grains (.32 mg.) every three hours for several days. Use adrenalin or ephedrine only as a last resort. Oxygen should, by all means, be used and if the patient is breathing with difficulty and there are basal râles, tachycardia and/or gallop rhythm. The oxygen want should be met by external administration.

The mediate treatment consists of absolute rest for a period of at least three weeks. The patient should be kept in bed and restlessness should be controlled by sedatives. In order to avoid venous thrombosis the lower extremities should be moved from time to time but this should be passive rather than active. The xanthine preparations are started at this time. Incidentally, caffein sodium benzoate intramuscularly is the best stimulant during the period of shock. Aminophyllin is begun and is continued indefinitely, four tablets a day. The patient should be allowed to get up gradually in about six weeks. After three weeks in bed the patient can move about rather freely but should not even have toilet privileges.

Subsequent treatment should aim to get the patient back to a normal life. For a period of six months active exercise is interdicted and for a year the patient should avoid excesses in everything, eating, drinking, physical or sexual. I would urge above everything else that this patient be encouraged to get back to a normal life and call attention to the figures I quoted in the first part of this paper which showed that a very large number of patients, if they do not have fear of sudden death thrust upon them at all times, are able to, can and will get back to a relatively normal existence.

Summary

I have given you a rather fragmentary presentation of an extremely common disorder. Much has been written about the condition clinically and great has been the experimental work in the past twenty years, consequently much is

known about a condition about which, up until 1918 following the second paper of Dr. Herrick of Chicago, practically nothing was known. It would be impossible in a short time to present the innumerable facts concerning coronary occlusion. Many questions may arise in the minds of my auditors as they listen to the few remarks that I have just made, but they can not be answered in a short dissertation on a subject which is book length in extent.

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WARRIORS AGAINST DISEASE

American medicine, as an authority recently observed, has a weak spot. It is not a weakness affecting the patient—the sick man or woman anxiously seeking a return to health. Curiously enough, this weakness has helped the patient—for the weakness lies in the fact that the medical profession has been so busy fighting disease in experimental laboratories as well as at the bedsides of the ill that it has found little time to tell the public of its tremendous achievements.

The undeniable record is there for all who wish to read it. And it tells, through the figures, a dramatic and inspirational story of an endless battle against disease and suffering and death.

That battle has won victory after victory. In the period of a century and a half in this country, the life expectancy of man has nearly doubled from thirty-five to sixty-two years. During that time, typhus, once one of the greatest killers, has all but disappeared. Smallpox and diphtheria, dreaded specters not so long ago, have been robbed of their terrors. Other great scourges—typhoid, diabetes, tuberculosis—have been brought under control, and their mortality rates steadily reduced. . . .

Medicine is not an industry. But, like industry, it has rendered its greatest service to the people under a system which places no brakes upon the achievements of the individual, and which encourages any man, in any field, to develop his talents to the utmost.—*Lapeer County Press*, Lapeer, Michigan, Jan. 8, 1941.

Unusual Hypertension

A Case of Ten Years' Duration*

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■ SINCE it has been estimated that nearly 100,000 people die annually in the United States as the result of heart failure because of hypertension and that many more die from cerebral accidents and renal insufficiency, it is well to pause and give thought.

The systolic pressure in established hypertension varies from 150 to over 300 millimeters of mercury but it is usually about 200; the diastolic pressure varies from 90 to 180 but is usually about 110. The pressure readings (especially systolic) vary greatly among different individuals and on different occasions in the same individual. Repeated measurements must often be made before the customary blood pressure levels for a patient are discovered, uninfluenced by excitement, exertion, or fatigue. A very high diastolic pressure is usually a bad sign and a constant finding of such a pressure over 130 millimeters of mercury means that but a few months or years of life remain.

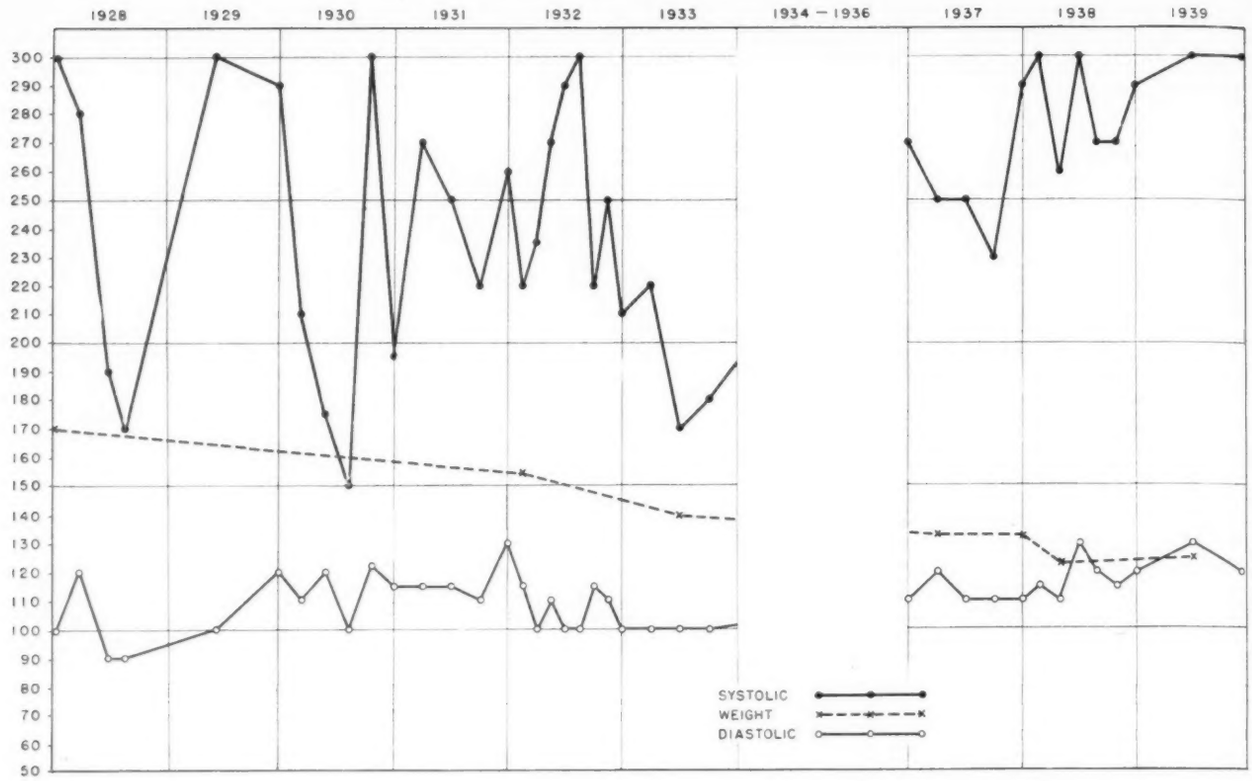
The following history is of a patient who first came to us in 1928, with a systolic blood pressure of 300 plus. Her blood pressure has remained high and now, eleven years later, shows the same systolic pressure; her retinæ show remarkably few pathological changes and her kidney function is very good.

Case History

A colored woman, now fifty-five years old, was first seen by us in 1928 when she complained of dyspnea on exertion and dizziness which she had experienced since 1924. In 1928 she started to have headaches. She had black spots in front of her eyes and became dizzy when reading; there was no epistaxis.

Family History.—Mother and father died of strokes, the former at fifty and the latter at sixty. Her first

*From the Cardiology Clinic, Harper Hospital.



husband is dead. Her second husband is living and well. One son living but tuberculous.

Physical Examination.—Weight 170 pounds. There were many snags of teeth, enlarged tonsils, marked pulsations of carotids and in supra-sternal notch, some râles at the bases posteriorly, the heart was enlarged to the left, there was a systolic murmur at the base and both systolic and diastolic at the apex. The blood pressure was 300 plus/110. There was no edema of the extremities. Rectal examination showed external and internal hemorrhoids. The blood and urine were negative. Blood non-protein nitrogen 30 mgs., and blood sugar 0.95 mgs.

X-ray Examination.—On March 30, 1929, the heart showed definite left-sided enlargement. Aortic shadow of normal size. No substernal thyroid. Slight increase in root infiltration.

Electrocardiogram.—Regular rhythm. Sinus arrhythmia. Marked left axis deviation. Inversion of T 2 and 3. Flat T 1. S-T 1 and 2 depressed. S-T 3 elevated. Conclusions: Marked myocardial damage.

Immediate Progress. While she was in the hospital with rest, diet, sodium bromide and chloral hydrate, and erythroltetranitrate, the blood pressure dropped to 170/90. Her menopause was about the middle of 1930. The patient was then seen at intervals in the outpatient department to October, 1933, and it was always noted that her blood pressure was in the hypertensive group. Once she complained of numbness of the left side of the face, the left arm and leg, but there was no disturbance in sensation. There was occasional shortness of breath and at different times she was given digitalis but never continued with it. Her electrocardiograms showed progressive myocardial degeneration.

Fundi.—On October 10, 1930, the fundi were within normal limits. Some of the vessels in the region of the discs showed presence of slight sheathing; some of the arteries were tortuous; venous pulsations presented a picture suggestive of arteriosclerosis.

Further Progress. We lost sight of the patient until February, 1937, at which time she showed a blood pressure of 280/100. The red blood cells were always essentially normal and there was only a slight reduction in the amount of hemoglobin. The blood non-protein nitrogen was always normal and the blood Wassermann test was always negative. She complained occasionally of being dizzy, tired, and listless. Her weight became progressively less. In 1938 there was a question of numbness of the left side of the body which appeared to increase. A neurologist made a diagnosis at that time of small but recurrent right sided cerebral hemorrhages. Occasionally she acknowledged some relief from phlebotomy and also was given sodium nitrites, capsules of theobromine and phenobarbital, digalen, and epsom salts. Her second husband died in October, 1938. In December her subjective symptoms were some shortness of breath, dizziness, and headache. There was no edema of ankles and feet. An electrocardiogram in May, 1939, gave the appearance of an old posterior infarction.

Fluoroscopy.—On March 30, 1939, a *fluoroscopic* study of the chest showed normal position of the diaphragm leaves with clear costophrenic sinuses and clear lung fields. The heart was enlarged in its transverse

diameter with particular enlargement in the left ventricular area which extended downward and towards the left and also posteriorly to a marked degree. No intracardiac calcification was demonstrable. The beat seen along the left border was regular and of small amplitude. There was very marked dilatation of the thoracic aorta although there was no aneurysmal dilatation at any point. The aorta exhibited a marked pulsation throughout. A radiograph taken at the six-foot distance showed considerable calcification in the transverse arch and the following measurements:

Internal diameter of chest	27.1 cm.
M L	10.8 cm.
M R	5.0 cm.
G V	7.6 cm.

Kymography.—A kymographic study in the anteroposterior and left lateral projections showed a regular cardiac beat of moderate rate and a very small amplitude in the left ventricular area suggesting myocardial damage. The pulsations of the aorta were of unusually large amplitude.

Eyes.—On June 14, 1939, vision in right eye was 20/100; left eye, 20/30. Pupils reacted to light and accommodation. Fundi revealed no evidence of hemorrhages. Vessels were quite small and wavy towards their periphery. They also showed white streaks along the surface but no other evidence of hypertension. Disc normal on appearance. No lens changes. The blood pressure in the right arm was 300 plus/110; in the left arm 290/110. Weight 122 pounds.

Discussion

A case of extreme systolic hypertension is presented in a colored female which was first diagnosed two years before the menopause. It has progressed for eleven years most of that time under observation with very few signs of heart failure or retinal changes and good kidney function. She has shown no signs of hyperthyroidism,[1] large vessel sclerosis, coarctation of the aorta, or arteriovenous communication and psychically is a quiet, rather phlegmatic, individual. (Recently she asked my advice about remarrying). Hence the diagnosis must primarily be essential hypertension.

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The attention of the medical profession is directed to the appearance of a special issue of *Harofe Haivri* (The Hebrew Medical Journal), a semi-annual publication, edited by Dr. Moses Einhorn. This volume commemorates the thirteenth anniversary of this journal and is dedicated to Prof. Sigmund Freud.

The Undescended Testis

By Louis J. Bailey, M.D., M.Sc. (Med.), F.A.C.P.
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■ In the descent of the testis the gubernaculum testis is not attached to the scrotum but to the peritoneum and to the fascia which surrounds the process of peritoneum which comes to be known as the processus vaginalis. The gubernaculum testis is also attached to the pubic spine and the perineum. Therefore, while a prominent rôle has conventionally been assigned the gubernaculum in guiding the testis to its normal scrotal position, it can only do so insofar as the processus vaginalis develops normally, descends normally through the inguinal canal and into the scrotum.

The physiological forces which control the development and normal direction of the processus vaginalis are not at all certain but it was proved experimentally in 1932[6] that the testes of immature rats and monkeys could be caused to descend by the administration of extracts of the anterior pituitary or pregnancy urine. The author noted in a series of experiments on rats in 1933 that the immature male was a better animal upon which to demonstrate the presence of A.P.L. than the immature female of the same age by virtue of the speed with which the testes descended after the injection of pregnancy urine or extracts containing A.P.L. Coincidentally, the seminal vesicles increased several times in size. These animals were twenty-one to twenty-five days old and younger animals were not used; but it is known from reports in the literature that more immature animals are more refractory to anterior pituitary or anterior pituitary-like hormones.

So far as I am aware, the human infant is the only mammal to exhibit descent of the testicle normally at birth. This fact has been quoted to indicate that the organ has been acted upon prenatally by the hormones circulating in the mother's blood, i.e., anterior pitui-

tary-like hormone, to cause descent, for the human female is the only one in whom this hormone can be demonstrated in the urine during pregnancy.

A similar hormone is demonstrable in the blood of the pregnant mare for a few weeks during pregnancy but there are some differences in the biological behavior of A.P.L. as found in human pregnancy urine and the hormone of pregnant mares' serum.

Spontaneous Descent

Despite the implication that the undescended testicle will remain refractory to hormone stimulation since it did not respond to A.P.L. during intra-uterine life, we are nevertheless confronted by the indisputable fact that the majority of undescended testes will descend during adolescent years. The figures vary widely;[3,7,12] but all are agreed that the various army statistics which indicate an incidence postpubertally of two or three cases per thousand men probably reflect the true incidence of undescended testicle in the adult. Therefore, Johnson,[7] who saw seventeen cases per thousand in over thirty-one thousand prepubertal boys, aptly inquires as to what happens during puberty to the other fifteen cases per thousand. In his five hundred and thirty-four cases, there was spontaneous descent in three hundred and thirteen, the age of spontaneous descent falling between seven and seventeen years, most being between nine and fourteen years.

Since undescended testicle is not commonly seen in association with Fröhlich's syndrome, it is unfair to assume that pre-adolescent hypopituitarism is commonly the cause. Nor can a lack of A.P.L. in the mother be considered as the reason for the failure of descent. The obvious conclusion is that the cause rests either in the testicle itself as a refractory effector organ or in developmental mal-development of the processus vaginalis and/or the gubernaculum testis.

Clinical Classification

Various classifications have been advanced,[3,10] the most useful being a clinical one:[3]

1. Those with an associated endocrinopathy.
2. Those with fixed mechanically retained testes or ectopy.
3. Those with movable testes which may be manipulated into the scrotum.

Treatment

Associated Endocrinopathy.—There is agreement that patients presenting other evidence of endocrine abnormality should be treated endocrinologically.[5,9,13,14] Thus it follows as a matter of course that the proper hormones will be exhibited in those patients with mental, physical or osseous retardation irrespective of the concomitant presence of cryptorchidism. Delay of appearance of epiphyseal centers with or without mental retardation will call for thyroid treatment; but the practitioner will probably prefer to exhibit A.P.L. in the dosages to be mentioned later if his patient is cryptorchid and not too young. Likewise Fröhlich's syndrome will be treated with thyroid, diet and anterior pituitary-like substances and if one or both testicles happen to be undescended in such a patient, descent of the organs will be accepted as an added dividend. I have not seen dwarfism in a young boy, but I should expect that this pituitary syndrome would be as refractory insofar as the gonads are concerned as it is in the young girl.

These cases frequently respond well to growth hormones but it is the usual thing for attempt at gonadal stimulation to fail.

Mechanically Fixed Testes.—There is no hurry in treating cases of undescended testicle unassociated with other endocrine defects. Prepubertally, the undescended testicle is no different histologically than the normally placed organ.[12,17] Indeed, with the record of spontaneous descent which has been quoted one might inquire as to whether the condition should be treated at all. The reasons most frequently given for early treatment, either hormonal or operative, are:

1. Histological damage to the testicle retained after puberty.
2. The possible occurence of carcinoma.
3. The possible occurrence of infection and injury.

The first of these is far and away the most important. Evidence that the retained testicle is more frequently infected or more frequently the site of carcinoma is not too conclusive.[2] There is ample evidence, however, that the retained testicle is different histologically postpubertally than the normal organ.[3,11,12,17] Whereas at

puberty the normally descended testis grows sharply and develops spermatozoa, the undescended organ grows slightly, develops usually only spermatogonia, rarely spermatozoa and later the germinal epithelium atrophies. Sterility is the rule in bilateral cryptorchidism,[10] the cause apparently lying in the increased heat to which the organ is subjected.[11]

It would seem reasonable therefore to prescribe treatment in all cases of bilateral cryptorchidism even though the chances for normal descent are greater than those for continued nondescent because of the loss of fertility which is bound to occur should the condition persist. Likewise, it would seem reasonable to prescribe treatment in unilateral cryptorchidism even though the chance of injury to organs retained in the inguinal canal be slight because hormone treatment is harmless and may accomplish complete results. Further, should hormone treatment fail, we shall have diagnosed those cases belonging in this category of the classification, i.e., those with mechanically fixed and retained organs.

Short of operation, the patient belonging in this category cannot otherwise be accurately diagnosed. It then becomes necessary to determine the age at which treatment had best be applied. If there is no other associated endocrinopathy, I see no objection to waiting until near puberty or the first years of puberty to prescribe hormone treatment. In fact the statistics relative to spontaneous descent would appear to demand delay.

Migratory Type.—The patient belonging in the third category of the classification, i.e., those with migratory testes, will almost inevitably show spontaneous descent. These cases require no treatment, obviously. But I see no objection to treating those in whom a low scrotal position is never seen for the same reason already given, viz., that one cannot positively determine whether or not mechanical obstruction is present.

Endocrine Therapy

Having decided to treat these patients and having decided the age limit during which treatment should be prescribed as preferably nine to fourteen years, one is faced with the necessity of choosing the endocrine substance to be exhibited. You will recall that anterior pituitary-like hormone is thought to exert its effect upon the patient's own pituitary gland, initiating the discharge of pituitary gonadotropic hormones. Because of its ready availability this substance has been most widely used in treatment of cryptorchidism. In addition, more latterly there have been available the pituitary hormone from pregnant mares' serum (Gonadogen) and one of the testicular hormones itself, testosterone, used as testosterone propionate. With the latter two substances I have no experience and merely wish to point out that the reports in the literature to date are too meager and too unsatisfactory to warrant furher comment[8,9] and that the pituitary hormone as it is now available extracted from the gland itself is not to be preferred over anterior pituitary-like substance.[1] It is therefore apparent that our choice of therapeutic material is limited to extracts of pregnancy urine (A.P.L., Antuitrin-S, Follutein, et cetera.).

Dosage.—A review of the literature would indicate that doses of from 100 R.U. twice weekly to from 100 or 1000 R.U. daily have been administered. The total effective dose reported has varied from 2400 to 7500 R.U.[1,4,12,14,16] and the total duration of treatment has been reported by these same authors as from three to twenty-five weeks, the average being about 2 months. I am in agreement with the discussant of one of these papers[16] that our peak dose need not exceed 1500 R.U. weekly. This would mean in the case of concentrated Antuitrin-S containing 500 R.U. per cubic centimeter a dose of 1 c.c. three times a week which can if you wish be given by the parents at home similarly to the administration of insulin to diabetic children.

This dose had best be obtained by degrees. We do not see the local or constitutional reactions with Antuitrin-S today as were seen a few years ago when the first products were released for commercial consumption. It is, nevertheless, my habit to give 100 R.U. per dose during the first week of treatment, increasing to 250 R.U. per dose in the second week and thereafter administering 500 R.U. per dose two or three times a week.

Results

The results to be expected from hormone treatment have been amply recorded. Permanent

descent in 61 per cent of treated cases as reported would appear to be entirely too high a result. As you are well aware, the literature has constantly cautioned against including migratory cases as cases of true cryptorchidism. Other observers have reported permanent descent in from 19 to 45 per cent of their cases.[1,4,12,14,15,16]

Operative Results.—Such results would appear to indicate that operation will be necessary in the majority of cases if a good scrotal position is to be obtained, and I believe this to be the case. In one series of seven patients treated surgically after failure of A.P.L. all showed anatomical reasons for the failure.[14] Operation was necessary in 75 per cent of Thompson's cases.[16] I should like to emphasize again, however, that the use of A.P.L. pre-operatively is valuable as an aid in the selection of cases for surgery and as a means of enlarging the structures to be found at operation.

The results to be obtained by operation appear to have been inadequately evaluated. McKenna[10] was unable to examine his cases postoperatively to prove the presence of sperm. Schuck operated on ninety-seven of 200 and noted that the growth of the operated organ was not improved.[13] Wangensteen[17] called attention to the fact that operation was incapable of completely restoring the germinal epithelium to normal function. Such restoration is possible in the experimental animal whose testes are returned to a normal scrotal position after having been temporarily resident in the abdomen; but this appears not to follow in the human being.

Endocrine Therapy.—In this connection I should like to call attention to the fact that the use of A.P.L. postoperatively is frequently recommended to improve the growth of the structures which have been restored to the normal scrotal position. However, I have never seen enlargement and have not been convinced by reports in the literature that the size of the testicle itself is ever influenced significantly by the administration of anterior pituitary-like hormones. If you recall that the action of anterior pituitary-like substance is almost wholly luteinizing in the female and interstitial cell stimulating in the male, it becomes manifest that the prime results to be obtained upon exhibition of this substance in the male is the elaboration of testosterone and the consequent development of the evidences of testicular hormone effect such as the growth of body hair, the change of voice, enlargement of the prostate, enlargement of the seminal vesicles, et cetera.

I have every reason to believe that testicles are capable of developing an interstitial cell mass without at the same time development of seminiferous tubules. It has been my good fortune to study the case of a young man because of his sterile union who showed every evidence of good masculine development except for the presence of two pea-sized testicles in a mid-scrotal position. The semen was somewhat deficient in quantity, measuring about 2 c.c. and not a single sperm was visible in the specimen.

Recommendations

I should like to make a recommendation based on known physiological principles. I should like to recommend that the follicle-stimulating hormone as it is today available extracted from pregnant mares' serum* be used in cases of cryptorchidism postoperatively with or without the concomitant use of A.P.L. The so-called follicle-stimulating hormone when exhibited in the male is known to exert its effect on the seminiferous tubules and the germinal epithelium. I have no experience with this type of postoperative treatment, having only discovered a suitable case within the last few days, but I feel obligated to call the theoretical considerations to your attention inasmuch as the maintenance and restoration of fertility are the prime objects of the treatment of cryptorchidism rather than simply to obtain a cosmetic effect.

Summary

The causes of cryptorchidism are not completely elucidated.

Most cases appear to depend on anomalous conditions of the peritoneum covering the spermatic vessels and vas and the appearance of fascial bands obstructing complete descent.

Hormone treatment should be tried during the first years of puberty (nine to fourteen years) as a means of differentiating cases with mechanical obstruction, as an aid to surgery and to effect descent in about 20 per cent of the cases.

*The dose is unknown but might well be 10 units twice weekly over a prolonged period.

A.P.L. should be used in doses sufficient to induce pubertal changes such as hair and genital growth which will require doses up to 1000 to 1500 R.U. weekly for an average of two months.

If operation is done, it should be done within the same age limits and should be followed by hormonal treatment to insure the restoration of the germinal epithelium without which any treatment is to be considered a failure.

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Michigan has been making big strides in developing its maternal and child health program, according to the latest reports to the Children's Bureau.

Commenting on the census figures, the Bureau states Michigan's maternal death rate declined from fifty-two in 1936 to thirty-six in 1937. In 1938 the rate was thirty-seven, but the one point increase was not sufficient to be statistically significant in view of the number of births involved, the Bureau points out. Michigan's 1938 rate was also held by three other states—Indiana, New Jersey, and Vermont.

Michigan's infant mortality rate in 1938 was forty-five per 1,000 live births, a drop of three points compared with 1937. One other state, Idaho, had the same rate as Michigan, while seventeen states had lower rates. The lowest state rate—thirty-six per 1,000 live births—was established by Connecticut and Nebraska.

There are still too many avoidable deaths of mothers and young babies in the United States, according to the Children's Bureau. Although the maternal and infant mortality rates for the United States in 1938 were the lowest on record, it is estimated that at least one out of two maternal deaths, and one out of three deaths of young babies can be prevented.

Congenital Umbilical Hernia
With Eventration

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■ THE NUMBER of cases of congenital umbilical hernia with eventration reported in the literature are few enough to make each case interesting. Most of the case reports are found in the foreign literature,[1,8,9,10,12,15] only a few being in our own.

The case we are reporting is as follows:

Mrs. C. R., aged twenty-eight, para II. Last menstrual period September 2, 1937, making estimated date of confinement June 9, 1938. Previous pregnancy March 25, 1936, at which time a normal 8 lb. 3 oz. full term female was born. No complications or postpartum morbidity were present.

Patient gave a normal menstrual history. Onset age 12, 28/7 type. Childhood diseases consisted of pertussis, measles and mumps. No operations except tonsillectomy and adenoidectomy.

This pregnancy was uneventful except for nausea and vomiting during week before admission to hospital. Onset of labor was exactly two weeks before expected date. The patient entered the hospital in labor and delivered 4 hours and 12 minutes after onset. Blood pressure on admission 90/50, pulse 96, temperature 98.8. Fetal heart was 140 on admission and rose to 158 one hour later. No analgesics or sedatives were given patient during labor.

The baby was a 6-pound 4-ounce female, born spontaneously after a midline episiotomy. It cried vigorously and required no resuscitation of any kind.

At the time of birth it was noted that approximately 14 inches of the ileum, cecum and ascending colon were lying free, outside of the abdomen. There was no sign of a hernial sac. The opening in the abdominal wall was fully the size of a half dollar, and the umbilical cord was attached to the left of this opening. As soon as the baby was born, the intestines were wrapped in warm saline sponges and within twenty minutes the infant was taken to the operating room. By this time, practically all of the intestines were outside of the

abdominal cavity. This was thought due to the release of intrauterine pressure.

Under drop ether anesthesia, the opening of the abdominal cavity was extended above and below, and after considerable difficulty, all of the intestines were

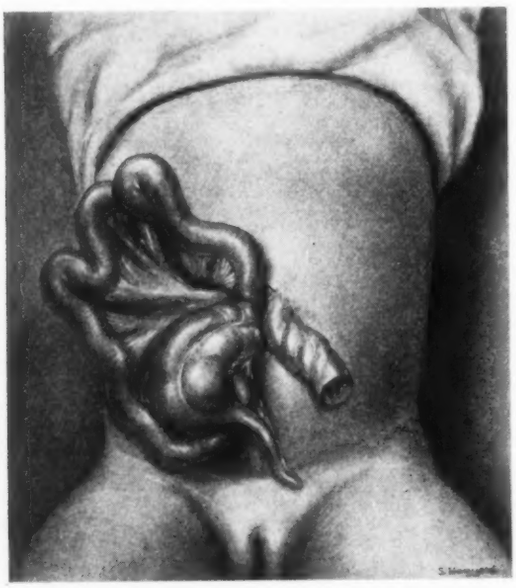

Fig. 1. Drawing of baby as it appeared immediately after birth, showing the umbilical cord to the left lateral side of the opening; the cecum, appendix and small intestine.

placed back in the abdominal cavity. Through and through silk sutures were used to close the abdominal opening, after having excised the umbilical cord.

The baby lost weight during its first three days, going down to 5 pounds 11 ounces. At the time of its dischange, on the twenty-fifth day, it weighed 6 pounds 12 ounces. The only abnormality in an uneventful convalescence was daily partial regurgitation of formula and some vomiting, which had entirely disappeared by the twelfth day. The baby was discharged on the twenty-fifth postpartum day and has been in perfect health since. At the present time (November 21, 1939), the child is normal and active, weighing thirty-two pounds and twenty-three inches tall.

It is obvious that this congenital defect is rare, when it is estimated that it occurs only once in 5,000 deliveries.[5]

Embryological Factors

Stein and Gerber[13] stated some of the embryological factors related to this subject as follows: The primitive gut and ventral body wall are formed primarily by a ventral bending and fusing of the originally flat germ layers which rest upon the yolk sac.

On each side, the splanchnopleure first curves ventrally and fuses with the member of the opposite side in the mid line, to form the gut. Shortly thereafter, the somatopleure fuses in the same manner in the ventral medial line to form the body wall. It is apparent that a defective fusion of the two sides of the somatopleure would result in a more or less extensive medial cleft. The cleft may extend from neck to pelvis, associated with a stillbirth, or may be limited to a small portion of thorax or abdomen.

Further factors, given by other writers,[3,4,6,11] are listed as: Traction on the umbilical cord; undue pressure in the abdominal region because of faulty fetal position; inhibition of growth of the abdominal wall; a disturbed relationship between growth of the abdominal cavity and its contents; and accidental bands of adhesions. There is no evidence of familial tendency in this defect of development.

Summary

1. Report of a case, interesting because of uneventful convalescence, probably because of early surgery.

2. Presentation of a few points in embryological development of this area, with a few etiological possibilities, as mentioned by other authors.

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Michigan has added to its maternal and child health staff a consultant in pediatrics to work in organized territory through the local health departments in developing this pediatric consultant service. He is to act as consultant to local practitioners in pediatrics in rural areas and wherever such consultant service is not otherwise available. He also lectures to county and district medical societies on the practice of pediatrics, talks to lay groups on the care of children, and participates in the state program of postgraduate education through lectures in organized centers. He has recently completed a comprehensive study of all infant deaths in the year 1939 in the city of Flint.

Feminine Psychology

With Emphasis on the Gynecological and Obstetrical Phases

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■ The history of medicine is filled with recorded observations indicating that there are definite connections between psychological and physiological processes. Dr. Franz Alexander[1] has pointed out, in his "Medical Value of Psychoanalysis," that these connections were perceived almost intuitively from general observation in the prescientific and prelaboratory period," when the physician "laid a much greater stress on the psychological state of the patient and attempted to explain disease not only as a consequence of pathological changes in the different organs but as a consequence of the conditions of the patient's life"; that, with the growth of scientific research and detailed empirical observations, the introduction of psychological factors was naturally "resisted by the biologically orientated physician, who was reminded of those days, not long past, when medicine was a branch of sorcery and therapy a form of exorcism," and that "the invasion of medicine by psychology is felt by the majority to introduce an unknown factor, incapable of tangible and scientific definition and approach."

Somatic Effects of Psychogenic Disturbances

There has been abundant supportive evidence showing that psychogenic disturbances of the organs of the body, the functions of which are regulated by the autonomic nervous system, can result in definite anatomical and structural changes. The connection of the cortex with the visceral organs through the sympathetic and parasympathetic system is sufficiently well known, and this connection implies that essentially every peripheral physiological process, in whatever part of the body it takes place, can potentially be influenced by psychological factors. There is a complicated interrelation between the autonomic ganglia and the central nervous system, and all visceral organs receive nerve fibers both from central origin and from sympathetic ganglia which lie outside of the central nervous system. Therefore, the concept of the autonomic nervous system is much more functional than anatomical, because morphologically they are closely interrelated and the innervation of the inner organs is always mixed.

The sexual functions, in the broad sense, probably represent the most instinctive phenomena of organic life and, in the life of women, this function holds a most important place, for upon it depends the phenomenon of maternity. It is certain that, until recently, as far as woman is concerned, any education which touched upon her sexual life was essentially a denial of the instinctual basis for sex, and that many of the sexual disturbances which have spoiled the lives of more than one woman could have been avoided by rational education.

As Dr. Karl Menninger[4] has pointed out, the starting point for many gynecological manifestations on a functional basis is often to be found in slight, quasi-physiological disturbances. Sometimes it is a woman's great anxiety for maternity which leads her to consult a gynecologist, or sometimes it is a sexual manifestation which may form the starting point of errors of interpretation, thereby turning the woman's mind towards the idea of some real affection of her genital apparatus.

Relation to Inhibition

Research studies as to the psychological determinants of somatic symptomatology have made it quite apparent that many symptoms can frequently be explained by the assumption of psychological inhibition. In other words, a degenitalization of the genitals, as it were, can take place. Naturally, long-continued frigidity or vaginismus could not exist without some corresponding structural changes, or at least atrophy, of the tissues and glands, which is characteristic of any unused

part of the body. That the emotional life has some relationship to frigidity would appear to be demonstrated by numerous reported cases in which a reorganization of the psychic life results in pregnancies ten to twenty years after marriage.[3] Some gynecologists have gone so far as to postulate details of the physiological mechanisms of this phenomenon. Sellheim, in 1925, assumed that the emotional factors are reflected in an over-action of the ovaries, resulting in premature maturation of the follicles, so that ova are discharged which are not yet ready for fertilization. He believed that, in some cases, this could be cured by psychotherapy, in others by a gradual reconciliation of the woman to her sterility, and that this reconciliation served to decrease the pathological emotional stimulation of the ovary and hence allowed it to discharge normal ova, thereby terminating the sterility. In this connection, the conclusions of Benedek and Rubenstein[2] (based on independent observations which were then correlated simultaneously) are of interest:

1. The day-by-day study of vaginal smears and basal body temperatures provided a useful and enlightening method for analysis of gonad function of adult woman.
2. The psychoanalytic method could also be employed for a day-by-day study of the cycle of propagative function on the psychological level.
3. The simultaneous use of the two methods provided clear correlations between the physiological and psychological processes.
4. The investigation suggests that in the adult woman, it was possible to relate instinctual drives to specific hormone functions of the ovaries.
5. Whenever the metabolic gradient, correlated with the specific gonadal hormones, changes its direction or slope, the psychological material shows a change in the direction of the instinctual drive.

This was the first time that an accurate method has been provided, affording an approach to a study of the biological foundations of the instincts.

Frigidity.—To go back to the theme of frigidity, some women vomit after every act of coitus. Many patients stop vomiting during pregnancy when, by suggestion, after an anesthetic, they are merely told that the pregnancy has been terminated. There are innumerable devices used by patients to bring about self-punishment or to reject the pregnancy by vomiting, or to develop other sudden, inexplicable, severe symptoms. To be pregnant is a great psychic trauma to some women, and many difficulties developing coincidentally are, in essence, protestations and the wish to reject the child.

Pseudo Pregnancy.—There is also the so-called nervous or phantom pregnancy—pseudocyesis. Some women are haunted by the idea of maternity because they either so greatly desire it or fear it, and a curious group of phenomena can be developed, simulating pregnancy, with the exception of uterine gravidity, even to its very last symptom.

Menstrual Disturbances.—Coming to the uterus itself in its non-gravid form and functions, we think, first, of all those disturbances of menstruation which have been traced to a direct connection with the unconscious repudiation of femininity. Of these, amenorrhea is the most logical and dysmenorrhea probably the most frequent. But not infrequently, menorrhagia, metrorrhagia and even leukorrhea have also been identified as psychologically predetermined, and by removal or correction of the psychopathology, amelioration of the symptom becomes easier. The rejection of the female rôle, which is dependent on deep-lying hostility, is directed outwardly against men and inwardly against the feminine part of themselves by reason of which some women feel so inferior. There also arises a sense of guilt which is focused upon that part of the body where a repudiation of femininity has been made concrete. There is a wide variety of phenomena, ranging from behavior reactions through functional aberrations to actual structural changes. All of them may be visualized as representations in different spheres of a profoundly influential drive, the subjective aspect of which is a wish to repudiate femininity; that this may appear in the form of perverted symptoms has been known in some degree since the hysterical syndrome was first recognized. Recent studies in the endocrines have shown the presence of the products of the glands of internal secretion of the opposite sex, in varying degrees, in each individual.

Psychological studies have also clearly established, in some cases, the unconscious wish of the little girl to be a boy, based on the physical and social advantages accruing to the male sex, and this unconscious wish to repudi-

ate her femininity has been found to have been exaggerated later by the shock of the first menstruation, by defloration, or fear of childbirth. That the functional aberration which we call hysteria may become structuralized into various organic changes is at least a logical hypothesis, but it is not yet proved.

It can be agreed certainly that any symptom may be psychogenic, chemogenic or physiogenic, and that any disease may be considered as a combination of all three, but none can represent any one of these factors alone. We attempt to interpret the psychological aspect of these conditions with the physics and chemistry with which we are more familiar.

Puerperal Psychoses

In the past it has been common to describe certain psychoses occurring at physiological epochs and to give them the name of the epoch during which they occurred, e.g., the "puerperal psychoses" and the "lactational psychoses." Infection and exhaustion are frequent causes operating at such periods to produce mental disturbances. A large number of these psychoses are, in reality of the infection-exhaustion type. Psychogenic factors are also of prime importance. A depression during pregnancy may mean that the wife is not in love with her husband and, therefore, does not want his child. It will be understood, however, that the strains incident to pregnancy, parturition, the puerperium and lactation may produce outbreaks of various psychoses, particularly dementia precox. There is no such thing as a "puerperal psychosis" strictly speaking. Mental disorder frequently occurs during the puerperium but must be classified in accordance with the symptoms it presents rather than the time of onset. A patient may be too immature to withstand the responsibility of motherhood. Patients who have had a history of a psychotic episode at parturition should be advised not to have further children, especially where there is a clear-cut psychotic episode with regressive symptoms, and where there is no evidence to show that the condition is primarily a toxic or infectious one. A history of fever with delirium, or evidence of renal damage or circulatory failure usually rule out the toxic, infectious cases. We have had occasion to see patients who have been advised by physicians to marry and have a child as a therapeutic measure to get over a previous nervous breakdown. We feel that this is unwise advice as, by superimposing added emotional strains upon an already overburdened personality, one may precipitate a more lasting mental condition.

Climacteric Changes

Among the most common and intractable psychological problems with which the gynecologist must deal are the involutional depressions or the beginning melancholia at the climacteric period. **In general, these conditions are found in a rather characteristic type of woman. Usually, these women have been somewhat indulged or pampered, have loved the idea of being loved, have found narcissistic satisfaction in being wanted, and have basked in the affection bestowed upon them rather than in the fact that they gave in love. This is true in general but not necessarily so in every case. When such women approach the menopause, they resent the physical changes in their appearance, feel they are not loved or wanted, develop ideas that their husbands are unfaithful because they are no longer as attractive as formerly, or develop ideas of unworthiness and self-accusation.**

In many such cases, removal from the home and placement in a sanitarium becomes a necessity. A new environment with new associations and different interests can be utilized. Theelin, particularly in larger doses, has been found to be of great value. The families of such patients should be advised to be more tolerant, patient and encouraging, and every effort should be made to safeguard the patient's ego. A feeling of "belonging," of making a contribution to family life, is an important psychological device in improving the mental attitude of such patients. This is a psychological epoch in the life history of a woman and should be dealt with sympathetically by her family and in a patient, understanding way by the physician.

Summary

In summary, the problem of feminine psychology cannot be related to factors inherent, namely, the anatomical, physiological, psychic characteristics of women alone, but also must be consid-

ered as importantly conditioned by the culture complex or social organization and the individual psychology, through the experience of the woman herself in terms of her early relationships and training.

Some of the theories advanced may sound fantastic, but it is suggested that they may be only foreign to our usual thinking. If one wishes to have more than a mere emotional judgment, there is only one way scientifically valid—a testing of the facts.

Repeated observations, case material, contrasting attitudes on the part of the individuals from the social, economic and cultural standpoints, show the universality of these dynamic factors which have been described. Such scientific observations as to the frequency of the types described give the social factors relatively slight value, while difficulties in personal development, when repeated as traumatic events and as disturbed relationships, can be seen as more significant. Such emotional conflicts, which are accompanied by their physical counterparts, can best be dealt with by the understanding physician when the symptoms first present themselves.

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"IF THIS BE TREASON . . ."

Is the American Medical Association a trust? Yes, it is—a sacred "trust." From its very beginning the A.M.A. has considered the health of the American people above all else. It led the fight against diploma mills, and through its efforts medical education was placed on its present high plane. The A.M.A. was instrumental in raising the standards of hospitals so that today American hospitals are the finest in the world. It has striven continuously to give the American people the best quality of medical care that the people of any great nation enjoy. But, because it does not fall in line with all the schemes proposed for the distribution of medical care, the A.M.A. must now be purged.

We say, in the words of Patrick Henry, "If this be treason, make the most of it!"—*Milwaukee Medical Times*, reprinted in *Illinois Medical Journal*, January, 1941.

Clinico-Pathological Conference

Detroit Receiving Hospital

Thursday, December 5, 1940

S. T., a colored man, forty-six years of age, was admitted to the hospital on June 5, complaining of shortness of breath and swelling of the ankles of three weeks' duration, and hiccoughing of two weeks' duration.

Present Illness.—The patient had felt as well as ever (including a completely normal exercise tolerance) until November of the preceding year, when he started to notice generalized weakness and mild pains in his knees without swelling or appreciable disability. During the winter he had several episodes of pain in his finger tips which he attributed to frost-bite. About three weeks before admission his fatigue increased and he became short of breath upon even mild exertion. There was slight intermittent painless swelling of the ankles which usually came on in the evening and disappeared by the following morning. He went to a private physician who took a blood test and told him his blood was "bad." He then gave the patient three intravenous injections of a yellow medicine. About two weeks prior to admission he started to hiccough and continued to do so.

Past History.—General health good. Malaria in 1912. Penile lesion at age of 17. Received no treatment until 1930 (age 36) when he was given an indeterminate number of hip and arm injections. He had had occasional treatments since. No history of rheumatic fever. No previous severe illnesses or hospitalization.

Occupational History: Odd jobs.

Family History and Marital History: Not of contributory value.

Physical Examination revealed a poorly nourished though well-developed colored male lying flat in bed and hiccoughing. Height 5'8", weight 119 pounds. Temperature 99.8°, pulse 114, respirations 25. Eyes: pupils were equal and regular, reacting normally to light and upon accommodation. The ocular fundi showed normal vessels and disks. There were no hemorrhages or exudates. No icterus of the scleræ. No petechiæ. Ears and nose: negative. Mouth: mucous membranes were pale but not otherwise remarkable. Neck: no venous engorgement but marked carotid artery pulsation. Trachea in midline. No tracheal tug. No cervical or other lymphadenopathy. Lungs: normal resonance. Medium crepitant râles at bases. Heart: apical impulse palpable in the fifth interspace in the mid-clavicular line. Systolic thrill in first right interspace in parasternal line on deep expiration. No increase in supra-cardiac dulness. Rough blowing systolic murmur in the aortic area with a soft diastolic murmur heard also in aortic area and transmitted downward along the left border of the sternum and to the apex. At the apex the first heart sound was slapping in quality. Also at the apex there was a blowing systolic murmur, and a rumbling murmur which persisted throughout diastole without definite presystolic accentuation. Regular rhythm. Blood pressure: right arm 120/50; left arm 115/40, abdomen: liver and spleen not palpable. No masses or tenderness. No ascites. Extremities: collapsing radial pulse; normal reflexes. No edema. No clubbing. Rectum and genitalia: negative.

Laboratory Studies on Admission.—Urinalysis: specific gravity 1.016, sugar 0, albumin 0, sediment negative. Blood: Hemoglobin 9.0 grams, RBC 2.98, index 0.9 WBC 4,000, neutrophiles 80 per cent, eosinophiles 2 per cent, lymphocytes 18 per cent, icterus index 5.5,

blood urea 33 mg per cent. Kline and Kahn positive. Subsequent laboratory tests: 6/22—hemoglobin 9.0 grams. RBC 3.69, WBC 17,450, neutrophiles 88 per cent, lymphocytes 12 per cent. Blood sulfathiazole levels: 7/5—2.5 mg per cent; 7/8—5 mg per cent; 7/11—3.6 mg per cent; 7/15—2.9 mg per cent; 7/18—2.6 mg. per cent. Numerous urinalyses showed variations in specific gravity between 1.005 and 1.020, occasional slight traces of albumin. The sediments were almost always negative except for a few to 25 white blood cells on three or four occasions. X-rays and electrocardiograms to be reported.

Clinical Course.—During his hospital stay the patient ran a swinging type of temperature varying between 99 and 103 degrees. Sulfathiazole therapy was started on July 3, and there was a drop of the temperature to normal starting on July 4, and persisting to July 10. In spite of continuance of sulfathiazole therapy, the patient developed fever again ranging between normal and 102°. Sulfathiazole therapy was stopped on the twenty-first for a period of five days, and the fever persisted. The pulse rate was consistently elevated ranging between 80 and 130. During the period of normal temperature the average pulse rate decreased to about 100 and then subsequently became more rapid again. The respirations varied between 20 and 25 with occasional rises to 30 and a terminal rise to 45. The patient's hiccoughs disappeared and then recurred on several occasions without being very troublesome. He gradually lost weight, became generally weaker and expired on July 28 without developing signs or symptoms of localizing value.

Dr. Edward D. Spalding.—This is an interesting case because while in a good many respects the history and physical findings are quite straightforward and point in one direction there are one or two aspects which will bear considerable discussion. The history of this patient's illness does not contribute nearly as much as do the physical findings and laboratory data and so I shall comment upon it only briefly. The fact that he was perfectly well until seven months preceding his hospital admission should be kept in mind as being some evidence against a diagnosis of chronic rheumatic heart disease. The episodes of pain in his finger tips which the patient attributed to frost-bite are, in view of the other findings, very suggestive of the lodging of emboli in the fingertips which is commonly seen in bacterial endocarditis. I do not feel that the hiccoughing is of any diagnostic significance in this situation. In regard to the past history, the attack of malaria does not impress me as being connected in any way with his present illness. The inadequacy of the anti-syphilitic treatment greatly favors the possibility that a patient who has syphilis will develop cardiovascular involvement and is a point in favor of this as the basis for this patient's heart disease. The absence of a history of rheumatic fever is not of much significance since many patients with rheumatic heart disease lack such a history. In the physical examination the absence of petechiæ is noteworthy. The history of the episodes of pain in his finger tips may be equivalent in importance and thus counterbalance the former. The absence of a tracheal tug is also significant but again its presence would be much more significant since it is always pathognomonic of an aneurysm of the aortic arch. Unfortunately, it is frequently absent in aneurysms of the aorta in general and also in some aneurysms of the aortic arch. The lack of engorgement of the cervical veins and the normal area of supracardiac dulness are further evidence against the presence of an aortic aneurysm, although the roentgenogram not infrequently shows an aneurysm when there are no physical signs to indicate its presence. The presence of the rough systolic murmur in the aortic area and the thrill in the first right interspace bring up the possibility of either a rheumatic or arteriosclerotic aortic stenosis or a roughening of the aortic valve due to the presence of bacterial vegetations. The lack of presystolic accentuation of the apical diastolic murmur in the presence of a regular rhythm is against the causation of this murmur by a rheumatic mitral stenosis.

Therefore, we are probably dealing with syphilitic aortic insufficiency and this finding at the apex is probably an Austin-Flint murmur. I have a good definition for two of these atypical cardiac murmurs which so frequently lead to confusion. The Austin-Flint murmur may be defined as a diastolic murmur at the apex of the heart occurring in an admitted case of aortic insufficiency that leads one to suppose that there may be a mitral stenosis; and in the same way a Graham-Steele murmur may be defined as a diastolic murmur at the base of the heart in an admitted case of mitral stenosis that leads one to suppose that there may be an aortic insufficiency.

From the cardiac findings, therefore, we can well explain the entire picture of a diagnosis of syphilitic disease at the aortic orifice without postulating involvement of the mitral valve. However, I cannot definitely exclude the possibility of rheumatic aortic stenosis.

One of the significant laboratory findings is the absence of red blood cells in the urine. Again this negative finding should not be given too much weight. I doubt whether the electrocardiograms will be particularly help-

ful in this case. From considerable experience in Clinico-pathological Conferences, one can make several inferences from some of the laboratory data which are present and from some of the laboratory data which are absent. The sulfathiazole levels combined with the clinical picture indicate to me that this man almost certainly had bacterial endocarditis since I can think of no other reason for which sulfathiazole would have been given. The mention of blood cultures has undoubtedly been purposely omitted.

In considering the course of this patient in the hospital, the fall in temperature which occurred on the day after the administration of sulfathiazole was started, is probably significant, in spite of the fact that the fever recurred while sulfathiazole was still being given, although at a slightly lower level. While sulfathiazole usually temporarily sterilizes the blood stream, the organisms remain buried in the heart valves where they are not susceptible to attack from the drug. Therefore, while the fever and bacteremia may be controlled in part by the sulfathiazole most types of bacterial infections persist.

I have recently seen a case with acute bacterial endocarditis in which the infecting organism was the micrococcus sicca, an unusual organism belonging to the group of gram negative diplococci such as, the gonococcus and meningococcus. This organism, like the others in its group, is apparently much more susceptible to the sulfonamide drugs and this patient was apparently cured although it is too soon to know whether this will be permanent. The organism in the present case is probably streptococcus viridans, a notoriously bad actor as far as response to treatment is concerned. In preferring the diagnosis of subacute bacterial endocarditis superimposed upon a syphilitic lesion of the aortic valve, I realize that there are considerable odds against this being the case since this complication is comparatively rarely seen. Chronic rheumatic heart disease with aortic stenosis and insufficiency, mitral stenosis and insufficiency and a superimposed subacute bacterial endocarditis must be mentioned as a very possible alternative diagnosis.

Dr. Saul Roseneweig.—**I should like to emphasize the fact that this patient had a temperature of 99.8° on admission to the hospital. Usually patients with valvular heart disease exist on a lower pyrexial plane than other patients and, therefore, the presence of fever immediately arouses the suspicion of some complication.**

The x-rays may aid in the differential diagnosis of the cause of aortic insufficiency by showing a change in the left border of the heart indicative of enlargement of the left auricle when there is rheumatic heart disease with co-existing mitral stenosis. Also in such a case the electrocardiograms may show a tendency toward right axis deviation or heightened notched P waves which would not be seen in syphilitic aortic insufficiency. In this case I favor the diagnosis of subacute bacterial endocarditis with underlying chronic rheumatic heart disease with aortic stenosis and insufficiency and miteral stenosis and insufficiency for these reasons: (1) The accentuated first sound at the apex, (2) the loud aortic systolic murmur and thrill, and (3) the comparative rarity of syphilitic heart disease as the basis for bacterial endocarditis. In my opinion the absence of a presystolic accentuation of the diastolic apical murmurs is not inconsistent with the presence of mitral stenosis even though the cardiac rhythm is regular.

Further Studies

(Presented following the clinical discussion)

Fluoroscopic and roentgenographic examination of the chest showed moderate congestion in both lung fields. The costophrenic sinuses were clear. The heart was normal in size, shape and position. The cardiac pulsations were of the rocking-beam type. There was some widening of the aorta.

The electrocardiogram showed a normal axis and normal sinus rhythm. The P waves were upright, of normal size and contour. The T waves were of low voltage in the three standard leads and of normal voltage in the precordial lead. Electrocardiographic interpretation: "Probable myocardial damage."

The blood cultures were repeatedly positive for streptococcus viridans and varied as indicated in the accompanied illustration.

Résumé of the Pathological Findings

Final Diagnosis:

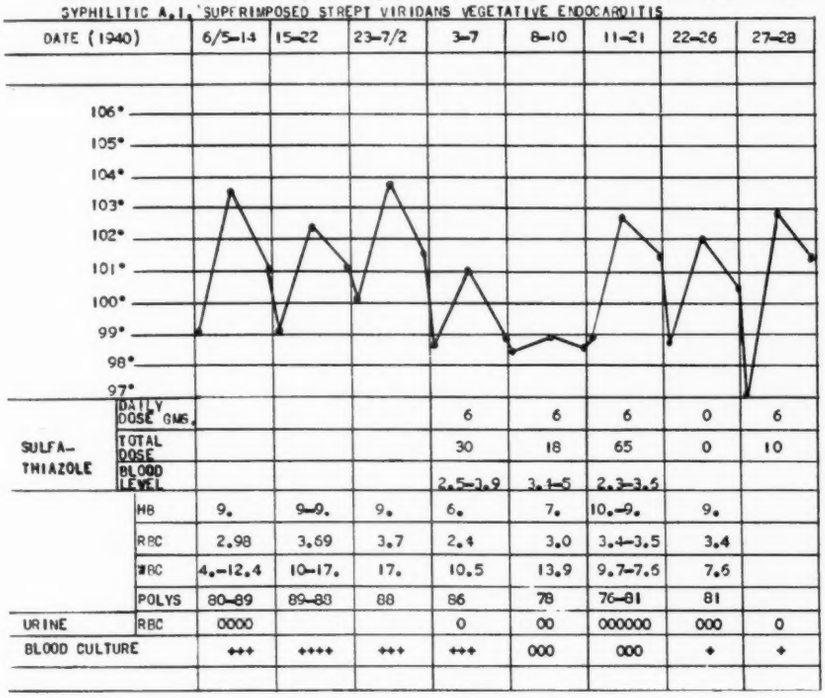
1. **Subacute bacterial endocarditis involving both mitral and aortic valves, chiefly the former, superimposed upon chronic rheumatic valvulitis.**
2. **Syphilitic aortitis and aortic valvulitis.**

The heart weighed 430 grams constituting Grade I cardiac hypertrophy. There was no pericarditis and mural thrombi were absent. There was widening of the commissures of the aortic valve and thickening of the aortic valve leaflets. The posterior leaflet was ulcerated and at this point there were attached small bacterial vegetations. The mitral valves were thick-

ened and fibrous and attached to the right cusp there was a large, soft, greenish-yellow vegetation. The circumference of the mitral valve was 11 cm. and that of the aortic, 7 cm. Microscopically there was nodular fibrosis of the mitral valve constituting evidence of preëxisting rheumatic infection. This was not satisfactorily demonstrated in sections of the aortic valve.

Dr. Paul H. Noth.—The response of this patient's disease to sulfathiazole therapy is illustrated in the accompanying figure. The temperature chart is a composite one for varying numbers of days as recorded on the topmost line.

S.T. X-8547 BL. M. AGE 46 ADM. 6/5/40 DIED 7/28/40 AUTOPSY DIAGNOSIS – M.I. SYPHILITIC A.I. SUPERIMPOSED STREPT VIRIDANS VEGETATIVE ENDOCARDITIS



DATE (1940)		6/5–14	15–22	23–7/2	3–7	8–10	11–21	22–26	27–28
SULFATHIAZOLE	DAILY DOSE GMS.				6	6	6	0	6
	TOTAL DOSE				30	18	65	0	10
	BLOOD LEVEL				2.5–3.9	3.1–5	2.3–3.5		
	HB	9.	9–9.	9.	6.	7.	10.–9.	9.	
	RBC	2.98	3.69	3.7	2.4	3.0	3.4–3.5	3.4	
	WBC	4.–12.4	10–17.	17.	10.5	13.9	9.7–7.5	7.5	
	POLYS	80–89	89–83	88	86	78	76–81	81	
URINE	RBC	0000			0	00	000000	000	0
BLOOD CULTURE		+++	++++	+++	+++	000	000	+	+

Aortic insufficiency was due chiefly to syphilitic valvulitis and this was contributed to by the presence of bacterial vegetations. Autopsy cultures were positive for streptococcus mitior (viridans).

The left pleural cavity contained 800 c.c. and the right 500 c.c. of fluid, the specific gravity of which was 1.015. The right lung weighed 720 grams and the left 800 grams. Both lungs were diffusely dark and firm. Microscopically there was a typical picture of chronic pulmonary congestion, the outstanding features being the presence of large numbers of heart failure cells in the alveoli and thickening of the alveolar walls due to connective tissue hyperplasia.

The liver weighed 1770 grams. The cut surface was mottled yellow and red, the lobular definitions being abnormally conspicuous. In the liver sections there was a wide anemic zone about each central vein composed of atrophic pale-staining liver cells. The pallor of this zone was due to edema superimposed upon passive hyperemia, the edema fluid having collected between the sinusoidal endothelium and liver rods, producing terminal narrowing of the sinusoids.

Excluding congenital valve defects, it is apparent that subacute bacterial endocarditis is usually, if not always, superimposed upon preëxisting rheumatic valvulitis, even though the presence of rheumatic infection cannot always be demonstrated. The presence of subacute bacterial endocarditis involving the aortic valve apparently superimposed upon syphilitic aortic valvulitis should probably lead to the suspicion of associated rheumatic valvulitis even though the evidence of rheumatic infection is largely obliterated by the syphilitic lesion.

After sulfathiazole therapy was started the fever decreased and then disappeared with an accompanying sterilization of the blood stream. However, in spite of continued sulfathiazole administration the temperature rose. Temporary withdrawal of the drug to exclude the possibility of its producing the fever was followed by a return to positive of the blood cultures. The drop in hemoglobin and red blood cell count occurred before sulfathiazole was started and, therefore, was not caused by it. Four other patients suffering from subacute bacterial endocarditis due to streptococcus viridans have been treated at Receiving Hospital with sulfathiazole. Three of these patients received no benefit from the drug as indicated by the continuance of fever and positive blood cultures. The fever of one patient subsided and his blood culture became negative for slightly more than one month, after which the fever returned and the blood cultures became positive in spite of continued administration of the drug.

Medical Rehabilitation of Rejected Draftees

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President's

Page

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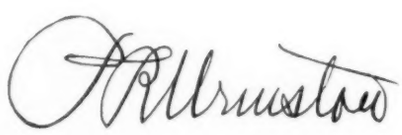
Rehabilitation of draftees with remedial defects—for industry and for the man—is the plan of the Michigan State Medical Society.

A study of the causes which have forced the Selective Service to reject young men for military work will first be made by the State Society. The reports the Society receives would indicate that medical care has been available to these youths but that most of the defects can be attributed to heredity or environment or in some instances to carelessness, disinterest and neglect. The State Society will investigate whether those in the relief, W.P.A. and depressed economic groups were given opportunities to obtain needed medical services.

After the study of causes has been completed, a program of rehabilitation will be outlined by the Michigan State Medical Society. This is planned primarily to aid the youth in having his remedial defects eliminated so that he may become more valuable to himself and to the community by usability in industry.



President, Michigan State Medical Society.

EDITORIAL

RELIEF FOR THE DOCTOR

■ NEGOTIATIONS, which have been in a rather nebulous state for several years and have become a very practical issue for some months, have culminated in a most constructive economic advance for the physicians of Michigan.

Mr. William J. Burns, Executive Secretary of the Michigan State Medical Society, made the initial contacts and a committee of The Council with Mr. Burns has finally secured a voluntary agreement with the representatives of the insurance companies active in Michigan, which should be most welcome to every practitioner (See page 123). It should definitely be realized that the fullest coöperation was forthcoming from the representatives of the associations of insurance companies both from the "old line," and the "mutual" companies as well as the "independent" companies of Michigan. Their enthusiastic aid was most acceptable and appreciated.

One of the headaches of the practice of medicine has been the fact that the attending physician to an automobile accident victim has too frequently been unable to collect for his services. The same situation also has been a vital problem for hospital management. Now there will be some relief from an unpleasant situation!

The gist of the agreement is that the patient, who has been injured in an automobile accident and for whom an insurance company is to be financially responsible, will sign an agreement giving the insurance company the right to make separate checks covering charges for services to the hospital and physician. There should be but little difficulty in getting this assignment from the patient while the memory of the service rendered is still fresh in his mind. The one agreement will cover both the hospital and the physician. The insurance companies have promised to assist the physicians in every possible way in getting these signatures and in the subsequent legal procedures.

Of course, there are a great many of these accident cases (not covered by any insurance) which must still be cared for as charity but at least the physician will know that if an insurance company is liable for the care of his patient, the money for his services probably will not be used by the "grateful" patient to buy a new car or a fur coat instead of paying the bills for services which saved him from pain, suffering, or even from death.

In Wisconsin a similar agreement has been in existence for two years. In Massachusetts there is a separate agreement for the physicians and for the hospitals.

If this works out as satisfactorily in Michigan as it has in Wisconsin and Massachusetts, physicians of Michigan, as did The Council, may well applaud the work of this committee which completed this welcome agreement.

BACK TO THE SEVENTEENTH CENTURY BY ORDER OF THE SUPREME COURT

■ THE Medical Practice Act under which we are operating says that anyone who wishes to practice "medicine, surgery and midwifery" must prove his qualifications and ability to safely perform these services.

In a recent decision, the Supreme Court of the State of Michigan has held that since the law does not say "and/or midwifery," one who practices midwifery alone is not legally required to qualify to perform this service and is under no supervision.

For some reason not known to the unjudicial mind this ruling does not apply to "surgery" even though the wording is the same. From a medical point of view it is impossible to intelligently divide these three parts.

Since the beginning of organized medicine in Michigan the medical profession has urged the utmost care in the supervision of qualifications to practice medicine, surgery and midwifery realizing that in order to continue with the prevention of maternal mortality this trinity must be indivisible. The knowledge of a belated lay interest in this search for the best care for the prospective mother makes this legal ruling seem to hark back to the dark days of the seventeenth century. Perhaps the newly gained social and po-

litical enthusiasm added to the pleas of our own profession may bring forth from the present legislature even more rigid supervision over the practice of medicine than exists at present.

L. Fernald Foster

Wm. Hyland

Wm. J. Burns

Roy Herbert Holmes

COUNCIL ELECTIONS

■ At the annual meeting of The Council held January 11 and 12 at Dearborn, Michigan, Treasurer Wm. A. Hyland, M.D., Secretary L. Fernald Foster, M.D., and Editor Roy Herbert Holmes, M.D., were reëlected to their respective offices.

The annual reports of these officers are printed in the Annual Proceedings of the Council elsewhere in this issue and portray the extent of activity of the Michigan State Medical Society.

The Council also unanimously re-appointed Mr. William J. Burns as Executive Secretary for another year. Perhaps the most significant testimonial to his activity is the increase in membership of the society from thirty-five hundred to forty-five hundred during his five years as Executive Secretary for the Michigan State Medical Society.

CORRECTION

In a letter commenting on the editorial, "Don't Nurse Your Babies," in The Journal for June, 1940, Docto- E. F. Daily, chief of the Maternal Health and Child Welfare Division of the Department of Labor, states that the Department of Labor does not have any supervision over the State Unemployment Compensation Commission. He says that the Social Security Commission sets minimum standards for the State Unemployment Commission.

How an Attorney General Thinks We Should Practice

MICHIGAN HOSPITALS AND MEDICAL PAYMENTS

(Accident Cases—Agreement of Insurance Companies, State Medical Society and Hospital Associations)

THE Michigan State Medical Society has conferred with hospital authorities and representatives of insurance companies to effect an agreement whereby hospitals and physicians may be more definitely assured of payment for their services to those individuals who are injured in accidents and who, because of their injuries, are indemnified by an insurance carrier.

Such an agreement has been reached. It has been carefully considered and incorporated in it are the best thoughts of those concerned.

Every physician member of the Michigan State Medical Society and every hospital superintendent is urged to read with exceeding care the information which is contained hereafter, as it is only through a thorough understanding of the provisions contained in the agreement that it can be effectively used.

The annual toll of those injured or killed as a result of automobile accidents has served to place an increased financial burden upon the hospital and the physician.

Seldom does the lay public appreciate the costs to the institutions and profession in the services rendered. Bandages, dressings, staff nurses, food, medicine, splints and the like are all items of expense.

There are 152 registered hospitals in this state. Their construction and equipment involve the investment of millions of dollars and their availability to a community is a matter of necessity. They serve a community purpose; they protect and promote the health and well-being of the people. Their charitable contributions are enormous but are so strained that imposition must be avoided wherever possible.

Inability to collect even for the initial outlay of materials constitutes a source of great financial strain and is becoming of such magnitude as to involve the welfare of the community served as well as of the people assisted. Insurance companies are willing and anxious to afford to the fullest measure possible that coöperation which will offer the maximum degree of relief to both professional groups and protection to the community at large.

It is appreciated that large numbers of such cases are indemnified in whole or in part from insurance protection. In countless numbers, however, the funds are dissipated by the patient, and the hospital and physician remain unpaid, despite the fact that the sett'ement was predicted, often in its entirety, upon the expenses incurred.

Insurance companies are appreciative of the problem. It is to their interest as financial concerns (and to the interests of their policyholders and claimants as well) to take all feasible steps to assist in the solution of that problem.

Prompt medical and hospital care is recognized as preventive of serious consequences in the greater number of cases. Early disposition of claims is conducive to the health and well-being of the patient, and is attainable through the prompt coöperation of patient, doctor and hospital.

Knowing that this problem existed, it was recognized that a satisfactory arrangement should

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*Medical endorsements are divided into two kinds: (a) includes only the guest in the automobile and not the named insured; (b) this type covers the named insured and the occupants. Both endorsements are sold only when a liability policy exists, and are endorsements to the general type of automobile liability policy sold. The medical endorsement covers expense for medical, surgical, dental, graduate nurse, hospital and ambulance services, and, in the event of death resulting from such injury, the reasonable funeral expense, all incurred within one year from the date of the accident.

be made for the payment of hospital and medical costs in those instances in which the injured party received remuneration from the insurance carrier.

It should be understood from the outset that this agreement is not a panacea for the physician's or hospital's financial problems in accident cases. It covers only those cases in which payment is to be made to the injured party by the insurance carrier, whether hospitalized or not, or where the insurance carriers, in accordance with their standard clause, pay expenses incurred by the insured for such immediate medical and surgical relief to others as shall be imperative at the time of the accident, or where indemnity is made under a medical endorsement.*

The Michigan Hospitals and Medical Payment Plan agreement has been approved by the American Mutual Alliance, the Association of Casualty and Surety Executives, a group of independent Michigan Insurance Carriers, the Michigan State Medical Society, and the Michigan Hospital Association.

There is established a conference committee to adjudicate disputes that may arise under its operation and to further coöperation to the end that if any hospital, physician or insurance company feels that it has a grievance, such grievance may be placed before it for mediation and arbitration.

The Committee is composed of one representative from the Michigan Hospital Association, one representative of the Michigan State Medical Society and two representatives of insurance companies.

The Conference Committee established under the agreement will elect a chairman and a permanent secretary. The secretary will receive any complaints from hospitals, physicians or insurance companies, in writing, and will place the complaints before the conference committee which has been established. The secretary will also act as a clearing house from which forms (1), (2) and (3) may be obtained. The cost of the forms in pads of 100 will be 50 cents. Cash must accompany all orders for blanks.

The effective date of operation of the Michigan Hospitals and Medical Payments Plan is March 1, 1941.

It is emphasized that the fundamental confidental relationship between the physician or hospital and patient shall be maintained under the agreement as it has in the past. Information relative to the injuries sustained by a patient as a result of an accident should be supplied to the insurance company only when the physician or hospital has on file the signed form which gives the hospital or physician the privilege to so inform the insurance company. Specifically the agreement provides "Insofar as possible the insurance company representatives will coöperate with the hospital and the physician in securing such orders."

As soon as the payment form (number one or two) has been signed by the patient, the original copy of this form should be sent to the insurance company, or companies, affected. Failure to obtain payment from the insurance company, due to the fact that it has no liability in the case, does not preclude the physician or hospital from obtaining payment from the patient. Likewise, if the settlement for the injuries is not sufficient to cover the hospital and medical care, the physician and hospital may obtain the unpaid balance direct from the patient.

The agreement which is made a part of this bulletin should be thoroughly discussed in hospital staff meetings and the procedure to be followed by the individual hospitals should be clearly understood. It is strongly recommended that the approval of the physician be obtained in all instances before the forms are mailed or given to the insurance companies by the hospital. Space has been provided on the forms for the signature of the attending physician.

The conference committee extends to all parties interested an invitation to place before the committee any suggestions, criticisms or complaints. If there is any question relative to the

operation of this plan, it may be submitted to the secretary of the conference committee.

The agreement, as approved by the Michigan Hospital Association, the Michigan State Medical Society, the American Mutual Alliance, the Association of Casualty and Surety Executives, and the independent group of Michigan companies, is printed in its entirety in the following paragraphs:

Michigan Hospitals and Medical Payments Plan

Doctors and hospitals have in the past experienced difficulties in securing the payment of charges from patients who have collected damages from persons causing their injuries despite the fact that in such cases a part of the patient's financial recovery actually was based on hospital, medical, and surgical expense.

Those principles are therefore enunciated in an effort to protect in so far as possible the interests of hospitals, medical and allied professions, insurance companies, the community and general public:

1. Except as the patient or his lawful representative may otherwise direct, the fundamental confidential relationship between the physician or hospital and patient shall be maintained. It is recognized that in order properly to submit a claim not only the early details of the injuries suffered must be disclosed, but also the expense which the injured party has incurred. In event of lawsuit or settlement, disclosure of this information is unavoidable, but the election so to disclose is that of the injured patient, and is his to be exercised. Therefore when so authorized by the patient, the physician and hospital will supply to the interested insurance company or companies complete information concerning the injuries and prognosis.

2. The obligation incurred by the injured party for necessary medical, surgical and hospital care is one primarily owing to either the physician or hospital. Payments by the insurance company by way of indemnifying the patient therefor should be applied toward the liquidation of such obligation to the extent such funds are available, and to assist therein, the insurance companies will recognize orders on proper forms for reasonable charges upon such funds which ultimately may become payable to the patient or his personal representative. In so far as possible, the insurance company representatives will coöperate with the hospital and the physician in securing such orders. Where the payment is insufficient to afford satisfaction to all parties concerned, the insurance company will endeavor to pay physicians' and hospital bills on an equitable basis.

3. In order that the insurance companies may furnish the fullest coöperation (and for the hospital's or physician's own proper protection) the physician and hospital shall notify insurance companies promptly of any claim upon which an order has been or may be issued.

4. In event of settlement with a patient who refuses or has failed to sign an order, the insurance company will endeavor to carry out the principles set forth in paragraph two and when this cannot be done will notify the hospital and physician before settlement or if such advance notice is not possible, then as soon thereafter as can be done.

5. The company shall pay any expense incurred by the insured, in the event of bodily injury, for such immediate medical and surgical relief to others as shall be imperative at the time of accident.

6. A Conference Committee of four, consisting of two insurance company representatives, and two representing the medical and hospital interests will be created to mediate disputes and to further coöperation.

N.B. Address orders for forms, inquiries, suggestions, or complaints for the attention of Conference Committee either to L. Fernald Foster, M.D., 2020 Olds Tower, Lansing, Michigan; or to Robert Greve, 1313 E. Ann Street, Ann Arbor, Michigan.

Form 1

Order for Payment
Medical, Surgical and Hospital Bill

..... 19...

To: .....
(name of insurance company)

.....
(Address)

If and when any settlement is made by you on account of my claim against

.....
(name of person(s) causing injury)

arising out of injuries sustained by me on or about....., and in con-
(date)

sideration of my being received for treatment by

.....
(name of physician or hospital)

you are hereby directed to pay the full amount of my bills for treatment, services and care to

.....
(name of physician or hospital) (address)

I understand this order does not relieve me of my obligations to pay such bill if not paid by your company, or any balance due after payment by your company.

Witness: Signed: .....
(signature of injured person)

.....

.....
(address)

This form has been approved by the American Mutual Alliance, the Association of Casualty and Surety Executives, a group of Michigan Insurance Carriers, the Michigan Hospital Association, and the Michigan State Medical Society.

Form 2

Order for Payment
Medical, Surgical and Hospital Bill
for Minor or Incompetent

.....,19...

To: .....
(name of insurance company)

.....
(address)

If and when any settlement is made by you on account of claims against

.....
(name of person (s) causing injury)

arising out of injuries sustained by

.....
(name of minor or incompetent)

on or about ....., and in consideration of such party being received for
(date)

treatment by

.....
(name of physician or hospital)

you are hereby directed to pay the full amount of the bills for treatment, services and care to

.....
(name of physician or hospital)

.....
(address)

I understand this order does not relieve the undersigned of any obligation to pay such bill if not paid by your company, or any balance due after payment by your company.

.....
(father or guardian)

Witness:

.....
(mother)

This form has been approved by the American Mutual Alliance, the Association of Casualty and Surety Executives, a group of Michigan Insurance Carriers, the Michigan Hospital Association, and the Michigan State Medical Society.

Form 3

Information Authorization

.....,19...

To: .....
(name of physician or hospital)

.....
(address)

You are hereby authorized to give

.....
(name of insurance carrier)

insuring the person or persons against whom (I) (We) have a claim arising out of injuries sustained by

.....
(name of injured party)

(or by me) on or about ....., or any representative of such insurance company,
(date)

a complete report of injuries and disabilities arising therefrom, hospital record and any other requested information pertaining to such injuries and disabilities, and copies thereof, and to permit it to examine the original records in your presenceif they should desire so to do.

Witness:

.....
(patient, or if minor, signatures of father, and mother, or guardian)

Approved:

.....

.....

This form has been approved by the American Mutual Alliance, the Association of Casualty and Surety Executives, a group of Michigan Insurance Carriers, the Michigan Hospital Association, and the Michigan State Medical Society.

MICHIGAN MEDICAL SERVICE

The steady growth of Michigan Medical Service during its first year of operation is but an indication of the continuous benefits possible for both subscribers and doctors. During this period, more than 7,500 patients will have been enabled to obtain needed medical services while more than 1,500 doctors will have received in excess of $240,000 for their services to these patients.

No one can yet measure the full effect of the medical service plan in making the services of doctors readily available or in preventing unremunerated services or bad debts for doctors. Certainly the prospects are most hopeful. Through Michigan Medical Service, the medical profession has an agency that can combat the medical economic problems which have beseiged doctors during the past ten years.

Improvements from Experience

The experiences gained in the actual operation of Michigan Medical Service during the first year afford a real basis on which to build improvements for the future. Many committees representing the various fields of medical practice—committees of the Michigan Dermatological Association, the Michigan Branch of the American Urological Society, the Michigan Association of Roentgenologists, the Detroit Roentgen and Ray Society, the Detroit Ophthalmological Society, the Michigan Association of Obstetricians and Gynecologists, and the Michigan Pediatric Society—have been called on by the Medical Advisory Committee to give expert counsel in regard to prevailing medical practices and to formulate definite procedures under Michigan Medical Service.

It is only through such close professional supervision that the functions of the medical service plan can be satisfactory.

Again, each doctor of medicine who has rendered services for subscribers to Michigan Medical Service can make the most important contribution toward the successful administration of the medical service plan by sending his suggestions, comments, or criticisms to the Medical Advisory Committee of Michigan Medical Service, Washington Boulevard Building, Detroit. So long as the Medical Advisory Committee is notified of situations which can be improved, progress can be made.

MICHIGAN MEDICAL SERVICE
REGISTRATION
HONOR ROLL

(As of January 10, 1941)

100 Per Cent

Barry
Mason

90 to 99 Per Cent

Calhoun
Menominee
Monroe
Newaygo
Tuscola

80 to 89 Per Cent

Allegan
Bay-Arenac-Iosco-Gladwin
Chippewa-Mackinac
Clinton
Delta-Schoolcraft
Dickinson-Iron
Gogebic
Gratiot-Isabella-Clare
Hillsdale
Ingham
Kent
Lenawee
Mecosta-Osceola
Midland
Oceana
O.M.C.O.R.O.
Ontonagon
Ottawa
Saginaw
St. Joseph

75 to 79 Per Cent

Branch
Eaton
Houghton-Baraga-Keweenaw
Lapeer
Muskegon
Northern Michigan
Wexford-Kalkaska-Missaukee

Know Your Michigan Medical Service

It is becoming more and more important for every doctor to know the full provisions of the Medical Service Plan and the Surgical Benefit Plan of Michigan Medical Service.

MEDICAL SERVICE PLAN: Patients who identify themselves as subscribers to the Medical Service Plan of Michigan Medical Service

will have a Michigan Medical Service Identification Card which carries the designating *Number 2*, indicating that the subscriber is entitled to *both medical and surgical services of doctors of medicine in the home and office as well as in the hospital*—including consultation services, x-ray, laboratory, and anesthesia services. Obstetrical services are not included until after the patient has completed twelve months of membership.

Under the Medical Service Plan, services necessary to establish a diagnosis *only* (no treatment) are provided for tuberculosis, venereal diseases, and mental disorders. For cancer and malignant growths, benefits can be provided only for the services necessary to establish a diagnosis and for the initial operative or radiologic treatment.

Medical Services for alcoholism, drug addiction, self-inflicted injuries, or for Workmen's Compensation cases are not benefits under Michigan Medical Service. Likewise, benefits can not be paid under Michigan Medical Service for drugs, materials, appliances or supplies. The patient is responsible for all services, drugs, appliances or supplies which are not provided for under Michigan Medical Service.

A recent liberalization of the Medical Service Plan is the inclusion of benefits for the surgical treatment of appendicitis and hernia whether or not the subscriber has had attacks previous to the date of his Certificate.

SURGICAL BENEFIT PLAN: Subscribers to the Surgical Benefit Plan may be identified by the designating *Number 3* on the Identification Card which indicates that the subscriber is entitled to surgical and x-ray services only when a bed patient in the hospital. Obstetrical care in the hospital after twelve months of membership is also provided.

The Surgical Benefit Plan is a low-cost, partial-service program and *provides only for surgical services when performed in the hospital.* Such services include the operative and cutting procedures for the treatment of diseases and injuries and for the treatment of fractures and dislocations. Strictly medical or diagnostic services in the hospital or surgical care in the home or office are not included as benefits under the Surgical Benefit Plan.

The x-ray benefits include diagnostic x-ray services not to exceed $15.00 during the subscription year for each person enrolled in the plan. Before benefits are payable for x-rays under the Surgical Benefit Plan, the subscriber must be a bed-patient in a hospital. However, as an extra benefit, payments will be made for diagnostic x-rays of a surgical condition taken in the office, if the patient has a surgical condition which immediately thereafter requires hospitalization.

Initial and Monthly Reports

Be sure to send an Initial Service Report for each patient for whom benefits are to be paid by Michigan Medical Service. By completing this short form carefully, it is possible to verify that the patient is in good standing and eligible for services. The exact spelling of the subscriber's name and the certificate number should be copied from the subscriber's Identification Card or Certificate. Each blank in this form should be filled in with the proper information. If there is some reason why the subscriber is not entitled to benefits under Michigan Medical Service, a notice will be sent by return mail. Unless the doctor is so notified, he will know that the subscriber is eligible for benefits.

As soon as the services are completed, but in no event later than the end of each month, a Monthly Service Report should be sent to the Medical Advisory Board for payment. This report is an itemized statement of the services rendered and should include an indication of each service rendered in order that the proper payment can be authorized.

Weekly Payments to Doctors

During the second year of operation, it will be the endeavor of the Medical Advisory Board to have payments made weekly to doctors. This will be possible if the doctor sends in his report promptly and gives in full the information requested. Delay in payment of Monthly Service Reports could be avoided if the doctor's office assistant would take the few minutes necessary to give all the pertinent information requested in the Monthly Service Report.

Michigan Medical Service opened its doors one year ago—February 1, 1940!

MEDICAL PREPAREDNESS IN MICHIGAN

The enactment of the Selective Training and Service Law of 1940 called upon the medical profession of each state to make a very great contribution to national defense. The physicians were asked to voluntarily make all the physical examinations of men selected for military service under the law.

The preliminary work for this program was very nicely accomplished by the Michigan State Medical Society when it formed a committee on Medical Preparedness following the lead of the American Medical Society. Under the able and enthusiastic leadership of Burton R. Corbus, M.D., past president of the Michigan State Medical Society, the State Medical Preparedness Committee quickly completed the formation of a Medical Preparedness Committee in each County Society. This pioneer endeavor of the State Society proved of inestimable value later.

The next operation was to organize a medical department in Selective Service Headquarters for Michigan to inform, assist and supervise the doctors in executing the physical examination program. Using the facilities of the Michigan State Medical Society, the State Medical Preparedness Committee and the constituent County Committees, the State Board of Registration in Medicine and the Michigan State Health Department, this volunteer organization of Michigan physicians was perfected with very little difficulty. Approximately one quarter of the physicians of Michigan are devoting a portion of their time to Selective Service. Of a total of 984 doctors of medicine, 705 are serving as Examiners for 192 Local Boards, 260 members of 19 Medical Advisory Boards, and 19 physicians on the 19 Appeal Boards.

The fact that hundreds of Michigan physicians so willingly coöperated in the venture speaks well for the medical profession in Michigan. The medical program is one of the most important portions in the Selective Service System. It is apparent from the reaction of the profession in Michigan that the doctors intend to do their part with distinction.

LT. COL. HAROLD A. FURLONG, M.D.
State Medical Officer, Mich. Selective Service.

REMISSION OF DUES OF MEMBERS IN SERVICE

The Council of the Michigan State Medical Society, upon authority of the House of Delegates, has ruled that active members of the Society with 1940 dues paid, who are serving their country away from home in the armed forces of the United States, will be relieved of paying 1941 dues, if recommended by the County Medical Society.

The Secretary of the County Medical Society shall fill out and return to the State Society, 2020 Olds Tower, Lansing, the following form for each of the members in his society whose membership is to be continued on the above basis. For the Secretary's convenience, a number of these forms will be sent to him by the State Society:

"This is to certify that....., a member of the
(name of member)
..... County Medical Society, was called into active service in the United States..... on ..... 19....,
(branch of service) (date)
and is now on duty at .....
(name of post and location)
and for that reason is entitled to remission of 1941 dues in the Michigan State Medical Society, in conformance with official action taken by The Council of the Michigan State Medical Society on November 10, 1940.

.....
(Name of Secretary) (County Medical Society)

The above does not apply to former members of the Michigan State Medical Society who were not members in good standing in 1940; but it does apply to physicians completing their medical education during 1940 or 1941 who are accepted as members of the county medical society during 1941 and who are inducted into active military service in 1941.

MICHIGAN PROGRAM FOR GRADUATES IN MEDICINE

Cooperating Agencies

Michigan State Medical Society
University of Michigan Medical School
Wayne University College of Medicine
Michigan Department of Health

Courses	Ann Arbor and Detroit	All Dates Inclusive
Allergy		May 12-16
Anatomy		February 12-May 28 (Wednesdays)
Diseases of the Blood and Blood-forming Organs		May 12, 13 and 14
Diseases of the Cardiovascular System		May 19-23
Diseases of the Genito-Urinary Tract		* .....
Electrocardiographic Diagnosis		* .....
Gastroenterology		April 28, 29 and 30
Gynecology and Obstetrics		* .....
Laboratory Technic		June 30-August 8
Nutritional and Endocrine Problems		March 3-6
Ophthalmology and Otolaryngology		April 17-23
Pathology: Special Pathology of Neoplasms		June 30-July 11
Pathology of the Female Genito-Urinary Organs		July 14-25
Special Pathology of the Eye		July 28-August 8
Special Pathology of the Ear, Nose, and Throat		August 11-22
Pediatrics		* .....
Proctology		* .....
Roentgenology		April 14-19
Summer Session Courses		June 30-August 8 and 22

Extramural Postgraduate Course March 24—April 18

Ann Arbor
Battle Creek-Kalamazoo
Flint
Grand Rapids
Lansing-Jackson
Mt. Clemens
Saginaw
Traverse City-Manistee-Cadillac-Petoskey

For further information, address:
Department of Postgraduate Medicine
1313 Ann Street
Ann Arbor, Michigan

*Dates to be announced later.

✶ YOU AND YOUR BUSINESS ✶

NATIONAL CONFERENCE ON MEDICAL SERVICE

The following five topics encompass most of the economic thinking of the medical leaders of the country:

Medical preparedness
Voluntary group medical care programs
Postgraduate plans of state medical societies
Medical legislative problems
Medical care for Social Security clients

These basic subjects will be presented in the form of symposia at the National Conference on Medical Service in Chicago on Sunday, February 16. The fifteenth annual meeting of the Conference will be held at the Palmer House. All Michigan physicians, particularly those who are interested in medical economics or in any one of this year's subjects, are cordially invited to attend the Conference. There are no dues or registration fees. The Conference marks an annual get-together of the best medical-economic minds of the country.

MICHIGAN'S INTANGIBLE TAX

The following is a hypothetical example of a report on intangibles based on Michigan's new intangible tax law:

Unpaid accounts receivable (as of 9/30/40)	$10,000.00	
Less unpaid accounts payable	1,000.00	
		$ 9,000.00
Bank deposits: Commercial Acct.	1,000.00	
Savings Acct.	4,000.00	
	$ 5,000.00	
Less exemption	3,000.00	
		2,000.00
Stocks and bonds (non-income producing)		5,000.00
Amount taxable		$16,000.00
Tax at .001 (1/10 of 1 per cent assuming the above items are non-income producing)		.001
Amount of tax		$16.00
Less statutory exemption		7.00
Intangible tax payable		$9.00

If any of the above properties are income producing, the maximum tax on that portion of the property is .003 of the value.

Life insurance policies are not taxable. Moreover, if two people, such as husband and wife, own a bank account jointly, each is considered to own one-half of the account and each is entitled to an exemption of $3,000 (unless there is evidence to prove that the account is actually owned by one of the two persons).

For detailed information and a copy of the booklet on Michigan's Intangible Tax Law, write Joseph H. Creighton, Manager, Intangible Tax Division, State Tax Commission, Lansing.

NOT A PRIVILEGED COMMUNICATION

"At a hearing in a personal injury case under the Workmen's Compensation Act, the plaintiff called a physician to explain the nature of his injury. The defendant thereupon called two physicians who had attended the plaintiff before the accident to show that the plaintiff's trouble was chronic and of long standing. The latter testimony was objected to by plaintiff's counsel as privileged. Held, that under the Michigan statute the calling of one doctor by the defendant waives his privilege as regards all who can testify regarding the condition in dispute." Lacount v. Van Platen-Fox Co., 243 Mich. 557, 220 N.W. 697 (1928).

MSMS DUES NOT RAISED

Dues of the Michigan State Medical Society have not been raised but remain at $12.00 per annum. While the Council was authorized by the House of Delegates to levy an assessment of $5.00 per member to cover emergencies, financial matters were so well arranged during the past year that no direct assessment or increase in dues was required. Dues are now payable to secretaries of county medical societies. Include your county society dues with the $12.00 dues of your State Society.

The State Society Convention

September 17, 18, 19, 1941

GRAND RAPIDS, MICHIGAN

MID-WINTER MEETING OF THE COUNCIL

January 11 and 12, 1941

FIRST SESSION

1. *Roll Call.*—The meeting was called to order by Chairman A. S. Brunk, M.D. in the Dearborn Inn, Dearborn, Michigan, 9:30 a.m., January 11, 1941. Those present were Drs. Brunk, Wm. E. Barstow, Otto O. Beck, Howard H. Cummings, T. E. DeGurse, Wilfrid Haughey, Roy Herbert Holmes, W. H. Huron, A. H. Miller, Vernor M. Moore, Ray S. Morrish, Roy C. Perkins, Philip A. Riley, E. F. Sladek, C. E. Umphrey; also President Paul R. Urmston, President-elect Henry R. Carstens; Secretary L. Fernald Foster, Treasurer Wm. A. Hyland, Executive Secretary Wm. J. Burns. Absent on account of illness: Drs. R. J. Hubbell and O. D. Stryker.

2. *Minutes.*—The minutes of the Executive Committee meetings, including December 19, 1940, were approved as published, on motion of Drs. DeGurse-Cummings. Carried unanimously.

3. *The Secretary's Annual Report* was read by Dr. Foster, as follows:

SECRETARY'S ANNUAL REPORT—1940

I herewith submit the report of the Secretary for 1940

The year 1940 marked another year of sustained effort in the execution of the many activities of organized medicine in Michigan. The established projects were continued and new endeavors initiated by THE COUNCIL, its Executive Committee and the various committees of the Society.

Membership

The total paid membership for 1940 was 4,478 (plus forty-three Emeritus and Honorary Members), with net dues of $46,174.02 accruing to the Society. The number of physicians with unpaid dues at the end of 1940 was sixty-three. The membership tabulation for the years of 1939 and 1940 showing net gains and losses, unpaid dues and deaths as follows:

1939	1940	Gain	Unpaid	Deaths
4,383	4,478	95	63	77

The present membership of 4,521, when compared with a potential membership of the eligible physicians in the State of 4,700, indicates that the saturation point is rapidly being approached and that future yearly increases in membership will be small.

MEMBERSHIP RECORD—1940

	1939	1940	Loss	Gain	Unpaid	Deaths
Allegan	23	24	–	1	–	–
Alpena-Alcona-Presque Isle	20	18	2	–	–	–
Barry	14	12	2	–	–	–
Bay-Arenac-Iosco-Gladwin	77	75	2	–	4	–
Berrien	68	64	4	–	2	–
Branch	24	23	1	–	–	1
Calhoun	117	120	–	3	–	3
Cass	13	14	–	1	–	2
Chippewa-Mackinac	23	23	–	–	–	1
Clinton	11	11	–	–	–	–
Delta-Schoolcraft	29	27	2	–	–	–
Dickinson-Iron	19	22	–	3	–	–
Eaton	28	32	–	4	–	2
Genesee	163	178	–	15	2	3
Gogebic	23	24	–	1	–	–
Grand Traverse-Leelanau-Benzie	42	41	1	–	1	–
Gratiot-Isabella-Clare	36	37	–	1	1	2
Hillsdale	27	26	1	–	–	1
Houghton-Baraga-Keweenaw	42	44	–	2	–	–
Huron-Sanilac	26	28	–	2	–	–
Ingham	141	143	–	2	–	3
Ionia-Montcalm	42	46	–	4	1	1
Jackson	93	94	–	1	1	2
Kalamazoo	118	115	3	–	3	1
Kent	234	244	–	10	6	6
Lapeer	16	15	1	–	1	–
Lenawee	44	43	1	–	–	–
Livingston	21	21	–	–	–	1
Luce	10	11	–	1	–	–
Macomb	39	43	–	4	–	1
Manistee	16	16	–	–	–	–
Marquette-Alger	40	43	–	3	1	1
Mason	9	10	–	1	–	–
Mecosta-Osceola	16	16	–	–	–	–
Medical Society of North Central Counties	23	22	1	–	–	2
Menominee	14	12	2	–	–	–
Midland	15	16	–	1	–	–
Monroe	35	35	–	–	2	1
Muskegon	79	80	–	1	–	2
Newaygo	13	13	–	–	–	–
Northern Michigan	33	37	–	4	2	2
Oakland	136	143	–	7	3	2
Oceana	11	12	–	1	–	–
Ontonagon	8	8	–	–	–	–
Ottawa	32	34	–	2	–	–
Saginaw	102	102	–	–	1	4
Shiawassee	31	29	2	–	1	1
St. Clair	55	52	3	–	1	–
St. Joseph	23	25	–	2	–	–
Tuscola	32	31	1	–	–	1
Van Buren	27	30	–	3	1	1
Washtenaw	174	173	1	–	3	3
Wayne	1,855	1,899	–	44	26	26
Wexford-Missaukee	21	22	–	1	–	–
	4,383	4,478	30	125	63	77
		4,383		30		
		95		95		
Emeritus and Honorary Members				43		
Paid Members				4,478		
Total				4,521		

Deaths During 1940

We regretfully record the deaths of the following seventy-seven members during 1940:

Branch County—A. G. Holbrook, M.D., Coldwater.

Calhoun County—Nils O. Byland, M.D., Battle Creek; Walter F. Martin, M.D., Battle Creek; Albert W. Nelson, M.D., Battle Creek, Stuart Pritchard, M.D., Battle Creek.

Cass County—C. M. Harmon, M.D., Cassopolis; John H. Jones, M.D., Dowagiac.

Chippewa-Mackinac—J. A. Reese, M.D., DeTour.

Eaton County—James B. Bradley, M.D., Eaton Rapids; C. A. Lown, M.D., Grand Ledge.

Genesee County—B. W. Malfroid, M.D., Flint; Herman G. Rosenblum, M.D., Flint; A. S. Wheelock, M.D., Flint.

Gratiot-Isabella-Clare—Ralph E. Dawson, M.D., Blanchard; C. D. Pullen, M.D., Mt. Pleasant.

Hillsdale County—William H. Ditmars, M.D., Jonesville.

Ingham County—Spencer D. Guy, M.D., Lansing; C. M. Watson, M.D., Lansing; W. G. Wight, M.D., Lansing.

Ionia-Montcalm—F. A. Hargrave, M.D., Palo.

Jackson County—John W. Page, M.D., Jackson; John C. Smith, M.D., Jackson.

Kalamazoo County—Edward Ames, M.D., Kalamazoo.

Kent County—T. P. Bishop, M.D., Grand Rapids; Willard Burleson, M.D., Grand Rapids; John F. Cardwell, M.D., Grand Rapids; C. D. Mulder, M.D., Spring Lake; Richard R. Smith, M.D., Grand Rapids; Frank A. Votey, M.D., Grand Rapids.

Livingston County—Charles E. Skinner, M.D., Howell.

Macomb County—Reginald P. Humphreys, M.D., New Haven.

Marquette-Alger County—J. D. Crane, M.D., Ishpeming.

Medical Society of North Central Counties—Ruey O. Ford., M.D., Gaylord; F. W. Lee, M.D., Fairview.

Monroe County—A. W. Karch, M.D., Monroe.

Muskegon County—R. G. Cavanagh, M.D., Muskegon; S. J. Drummond, M.D., Casnovia.

Northern Michigan Counties—Robert B. Armstrong, M.D., Charlevoix; J. G. MacGregor, M.D., Boyne City.

Oakland County—J. S. Morrison, M.D., Royal Oak; W. W. Wiers, M.D., Royal Oak.

Ottawa County—Milan Coburn, M.D., Coopersville; John G. Huizinga, M.D., Holland.

Saginaw County—Paul Kahn, M.D., Frankenmuth; Arthur E. Leitch, M.D., Saginaw; Emil P. W. Richter, M.D., Saginaw.

Shiawassee County—G. B. Wade, M.D., Laingsburg.

Tuscola County—J. E. Handy, M.D., Caro.

Van Buren County—Chester A. Wilkinson, M.D., Kendall.

Washtenaw County—D. M. Cowie, M.D., Ann Arbor; Theron S. Langford, M.D., Ann Arbor; Coral Adelbert Lilly, M.D., Ann Arbor.

Wayne County—J. M. Berris, M.D., Detroit; Josephus M. Burgess, M.D., Northville; Paul W. Butz, M.D., Plymouth;

Manley D. Caughey, M.D., Detroit; A. N. Collins, M.D., Detroit; L. Irving Condit, M.D., Detroit; A. J. D'Alleva, M.D., Detroit; John B. Dibble, M.D., Detroit; William A. Evans, M.D., Detroit; Thos. W. Ferguson, M.D., Detroit; Douglas L. Gordon, M.D., Detroit; Samuel F. Haverstock, M.D., Detroit; H. W. Hewitt, M.D., Detroit; E. C. Hoff, M.D., Detroit; Arthur G. Hubbard, M.D., Detroit; Jacob Levitt, M.D., Detroit; Walter H. MacCracken, M.D., Detroit; R. D. MacKenzie, M.D., Detroit; Wilson Randolph, M.D., Detroit; Bruno J. Sawicki, M.D., Detroit; Roy S. Smith, M.D., Detroit; Theodore H. Smith, M.D., Detroit; G. W. Stockwell, M.D., Detroit; Prosper D. White, M.D., Detroit; H. Wellington Yates, M.D., Detroit; L. L. Zimmer, M.D., Detroit.

Financial Status

The fiscal year closed December 21, 1940, and the statement of our certified accountants, Ernst & Ernst, shows the financial condition of the Society on that date. The following facts are noted:

The fiscal year of the State Medical Society closed December 21, 1940. Our certified accountants, Ernst & Ernst, have audited the books of the Society and have furnished an analysis of our financial situation. Their report reveals the following facts.

The assets of the Society are given as $39,214.40 as compared with $43,399.91 of a year ago. The smaller assets are due chiefly to allocation of $6,000 (market value) of securities to the Trustee of Medical Defense Fund. The net worth is $37,788.63 as compared with $24,224.35 last year, or a gain of $13,564.28.

There is a strong possibility that a part or all of the money advanced to Michigan Medical Service for organizational and working capital in the amount of $17,544.45 may be repaid during the coming year. The net worth of the Society will be enhanced to the extent that this is done.

The income from dues was $52,770 as compared with $51,518 in 1939, a gain of $1,252. Interest received totaled $829.18, a gain of $66.12 over last year. The total income was given as $50,070.52 as compared with $46,750.95 the previous year. These figures are found by deducting $6,595.98 allocated to the JOURNAL and adding the income from the JOURNAL of $2,740.96, plus interest received and miscellaneous income. The expenses of the Society totaled $36,125.24 divided as follows: The administrative and general $19,909.71, Society activities $10,696.89, committee expense $5,518.64. The expenses were $9,593.51 under the budget estimate.

The security portfolio, as a whole, has not been changed. Securities having a total market value of $6,000 were transferred to Dr. Wm. A. Hyland, Trustee for the Medical Defense Fund. Some bonds showed a total decrease in quoted market value of $637.50. Other bonds showed an appreciation in market value of $211.25. The U. S. Savings bonds showed appreciation due to interest accrual of $176.00. The old stock held by the Society decreased in market value $43.50. The bonds of the Hyland Trustee account showed appreciation of $172.75 and depreciation of $148.75 for a net depreciation of $23.75. The combined net decrease of all securities held in the State Medical Society and the Trustee accounts was $317.50.

The medico-legal defense fund account was closed the previous year (1939) by the allocation on January 13, 1940, of securities worth $6,000 to Dr. Wm. A. Hyland, Trustee. A separate audit of Trustee Hyland's account was made by Ernst & Ernst. It revealed receipts of $1,603.75 from the sale of securities, $387.50 interest received from securities and $75.00 repayment by members of M.S.M.S. of legal fees advanced by the Trustee. This makes total receipts of $2,066.25. Disbursements were for legal fees, $1,640.43 and premium on Trustee's bond, $12.50, totalling $1,652.93. The present bonds in Trustee Hyland's portfolio have a market value of $4,341.25 which, with cash on hand of $413.32, makes a total value of this account of $4,754.57.

To sum up—Income was higher by $1,252, expenses were higher by $1,349 and were less than the budget estimates by $3,026.36. The increase and net worth of the Society for the year was $13,564.28. The JOURNAL, while being subsidized from members' dues by $6,595.98, showed a profit of $2,740.96, an increase in profit over the budget estimate of $584.71. If it had not been subsidized it would have resulted in a loss of $3,855.02. The security accounts showed a loss in market value of $317.50.

From the above figures it will be noted that the Society was operated well within the budget requirements so that it faces the coming year in better financial condition than a year ago. The anticipated loss of income due to war activity in the next few years can probably be met by the substantial saving effected this year.

The 1940 Annual Meeting

An all-time high in attendance was established at the 1940 Session in Detroit. There was a total registration of 2,561.

The General Session type of scientific program was continued and was heartily endorsed by both the essayists and members.

A lack of available facilities precluded the possibility of a scientific exhibit at the 1940 meeting.

No expense was spared in bringing to Michigan an outstanding array of out-of-state speakers, and every possible provision was made to make the convention attractive. Despite the great expense incurred in maintaining the high standard of the Michigan meeting, a substantial profit again accrued to the Society as a result of the large and well-developed technical exhibit. The registrants at the convention showed their appreciation to the technical exhibitors by being very generous in their attention to this group.

County Secretary Conferences

Three County Secretary Conferences were held during the year. One in Lansing in January, one in Menominee for the Societies of the Upper Peninsula in July, 1940, and one in Detroit on the occasion of the Annual Meeting in September, 1940.

The January Conference was unique in that one of its sessions was held jointly with the County Health Directors of Michigan. A similar type of conference is planned for 1941. Such an arrangement brings together two important groups, provides for an exchange of viewpoints and helps to better correlate health programs.

Committees

Time and space do not permit a detailed account of committee activity, but 1940 marked a high point in committee endeavor. The development of a Preventive Medicine Committee by bringing together the chairmen of all health committees has added much to the efficiency of committee activities and has been responsible for better committee correlation.

To the already large group of committees was added the Medical Preparedness Committee and Conference Committee on Prelicensure Medical Education. The Preparedness Committee, working closely with a similar committee of the A.M.A., has and will continue to have much work to do.

Society Activities

During the year just closed, the 55th County Society Charter was granted. This was accorded the physicians of Huron County and marked the beginning of the "Huron County Medical Society."

As an innovation in 1940, THE COUNCIL approved the idea of holding "Councilor District" meetings. These replace the meetings known as "State Society Nights." Up to this time a district meeting has been held in practically each of the 16 Councilor Districts. In 1941 it is hoped that such meetings can be so correlated that they will follow closely after the Annual Meeting and thereby serve to stimulate the component units to

action on their programs and projects early in their fiscal year.

During 1940 your two Secretaries contacted practically all of the 55 county units. On most occasions they were accompanied by some members of THE COUNCIL.

It is gratifying to report that most of the Societies are well organized and are manifesting a keen interest in both the scientific and sociologic phases of medical practice.

Meetings are held regularly in most societies and attention is properly divided between scientific discussions and those of an economic and political character.

As a result of a recommendation by THE COUNCIL, the House of Delegates in 1940 decided to continue memberships without the collection of dues of all physicians called to Active Military Service. This splendid gesture has been followed by many county societies as well.

During 1940 twelve Secretary's Letters were issued, nine to Secretaries of County Societies and three to all members of the Michigan State Medical Society.

Michigan Medical Service

While Michigan Medical Service has been operating since March, 1940, as a separate organization, mention should be made of the fact that very strenuous demands have been made upon the time and energies of this COUNCIL, its Executive Committee, the Officers and Administrative personnel in the conduct of the affairs of Michigan Medical Service. These individuals have been most generous in this connection.

Your Secretary cannot express too sincerely and earnestly to this COUNCIL his appreciation of its fine coöperation and encouragement during the past year. Much commendation is due the committees for their splendid spirit and untiring efforts in the successful execution of many difficult tasks.

To Mr. Burns, executive secretary, and the executive office personnel, too much appreciation for their untiring efforts cannot be expressed.

Mr. Burns has been at all times most coöperative and helpful, and has been a continual source of inspiration and aid. To all those who have aided so generously in the discharge of the duties of this office, your Secretary is truly grateful.

Respectfully submitted,
L. FERNALD FOSTER, M.D., *Secretary.*

The report with recommendation re dues remission was referred to the County Societies Committee.

4. *The Treasurer's Report* and the *Trustee's Report* were presented by Dr. Hyland as follows:

TREASURER'S REPORT—1940

As treasurer of the Michigan State Medical Society, I wish to submit the following report for the year 1940.

As required by the by-laws of the Michigan State Medical Society, the usual indemnity bond was filed with the Secretary of the Michigan State Medical Society.

On April 15, 1940, the $1,000 Kresge Foudation bond was called at $1,040.00. It was decided by the Bond Committee to trade the Kresge Bond in the General Account for the Consolidated Oil Bond in the Trustee Account, in order to obtain cash for current Trustee Account bills without selling any of the Trustee Portfolio.

On August 1, 1940, the General Fund purchased the New York Central Railroad Bond from the Trustee Fund.

The present value of the bonds and securities held by the Michigan State Medical Society, market value as of December 21, 1940, is $22,811.25.

Total funds in my possession as Treasurer of MS MS, including bonds at quoted market prices $22,811.25 and cash in Michigan National Bank $707.59, total $23,518.84.

Respectfully submitted,
WM. A. HYLAND, M.D.,
Treasurer

Report of Trustee Fund of Michigan State Medical Society as of December 21, 1940

On January 13, 1940, the Michigan State Medical Society delivered to Dr. William A. Hyland, Trustee, the following bonds to hold as Trustee replacing the former medical-legal fund, their approximate value being $6,000.

Two New England Gas and Electric Company Bonds
Two Southern Pacific Railroad Company Bonds
Two Grand Rapids Affiliated Bonds
Two New York Central Railroad Bonds
One Consolidated Oil Corporation Bond

On April 1, 1940, the Trustee account sold one Consolidated Oil Company Bond to obtain money for current medical-legal bills.

On August 1, 1940, the Trustee account sold one New York Central Railroad Bond for current medical-legal bills.

Total received from sale of Bonds to Michigan State Medical Society	$1,603.75	
Interest received on Securities	387.50	
Repayment to Trustee Fund by member legal fees advanced	75.00	$2,066.25
Paid Legal fees amounting to	1,640.43	
Paid Premium on Trustee's Bond	12.50	
		1,652.93
Cash on Hand December 21, 1940		$ 413.32
Total amount of bonds turn over to Trustee by Michigan State Medical Society quoted at market prices of December 20, 1939	$6,000.00	
Interest on bonds	387.50	
		$6,387.50
Deductions:		
Legal fees paid	1,565.43	
Premium paid on Trustee's bond	12.50	
Loss on sale of bonds to M.S.M.S.	31.25	
Reduction of carrying amount of securities held in trust December 21, 1940, to quote market prices	23.75	
		1,632.93
Balance in Trust Fund December 21, 1940		4,754.57
On deposit at Michigan National Bank		413.32
Total market value of bonds in Trustee Fund		4,341.25
Total value of Trustee Fund		$4,754.57

WM. A. HYLAND, M.D., *Treasurer*

These reports were referred to the Finance Committee.

5. *The Editor's Annual Report* was presented by Dr. Holmes, as follows:

EDITOR'S ANNUAL REPORT

The selection of scientific articles for THE JOURNAL has been based primarily upon the needs and desires of the general practitioner who represents the key majority of the Michigan State Medical Society membership. Emphasis has been placed, therefore, upon short practical articles of a not-too-highly specialized nature and with most of the attention directed toward diagnosis and treatment of those conditions which are of importance to the man in private practice. The belief that this policy has been acceptable to this large portion of our membership, is enhanced by the fact that no adverse criticism has come to the Editor's attention.

During 1940. THE JOURNAL has published eighty-seven scientific articles averaging three and one-half pages in length. Of this number all were of a general nature: There were forty-three pertaining especially to internal medicine; twelve to eye, ear, nose and throat; nine to gynecology; six to surgery; five to obstetrics; three to orthopedics; three to pediatrics; three to economics; two to proctology; and one to urology. Of these papers, forty-nine were written by members of the Michigan State Medical Society; and thirty-eight were by out-of-state medical leaders, the original papers having been given at a state or county medical society meeting in Michigan. No other sources of scientific papers were used.

The Editor has attempted to stimulate the use of cuts, charts, et cetera, which aids considerably in impressing the reader. Every attempt has been made to keep the scope of papers for each issue well diversified.

There were turned over to the Editor this year some one hundred manuscripts ranging in priority of time from one month to two years. Those papers which pertained to such highly specialized subjects that the reader-interest would be negligible were returned to their respective authors so that they might be submitted to a specialized journal. The papers which were manifestly too long to hold the interest of the general practitioner or whose subject matter did not appear to warrant such extensive use of space were returned to their respective authors with a request that they be condensed; most of which requests were fulfilled.

It is believed that the use of many paragraph and sub-headings, extra spacing and the use of bold face type has improved the reader-interest in the scientific papers. While this takes extra time on the part of the Editor it seems definitely worth it. In the same category, the use of biographies of the authors and cuts, when already available, also add to the value.

During the past year the Editor has written and published forty-five editorials. Each editorial has been submitted to each member of the Publication Committee in order that there may be no conflict with the policy of THE COUNCIL. Eleven of these editorials were reprinted in nine other state medical society journals and two more were quoted.

Two departments were instituted: "You and Your Government," and "You and Your Business" under which heads a reader who may be interested would be able to find the material desired with the least possible inconvenience.

The general physical make-up of THE JOURNAL has also been changed during the year in an effort to make its appearance more modern and yet not lose the dignity of a scientific journal.

Only one typographical error has been invited to the Editor's attention during the past year.

Before outlining the plans for the coming year the Editor wishes to thank Dr. Haughey and his Publication Committee who have been most helpful and cooperative, and the Bruce Publishing Company who have lent every available facility both physical and technical. Without the aid of these adjuncts and Secretary Foster and Mr. Burns it would have been impossible to have accomplished these changes. To all of them and especially to Dr. Haughey and Mr. Burns, the Editor is deeply indebted.

Program for 1941

The so-called "throw-away" journals are simply "pirates" in the publication field since they abstract articles published in legitimate journals and print them to attract a certain class of readers in order to sell advertising which should go to the legitimate journals. They have been troublesome to all of us. In an attempt to take away some of their appeal and in order to provide the readers of THE JOURNAL with abstracts from articles published in other state journals and also to provide national scope for authors who publish articles in THE JOURNAL of the Michigan State Medical Society, we are instituting, this year a plan by which the author (when his manuscript is accepted) will submit a short abstract of the highlights of his paper. These will be made available at the time of publication to the other state journals and in time a system will be worked out whereby the readers of THE JOURNAL of the Michigan State Medical Society will have available, in abstract form, the cream of all scientific articles published in the United States.

Arrangements have been made with the Wayne University College of Medicine to publish each month, beginning in January, a clinico-pathological conference in concise and interesting form. It is believed that these will be very popular since they will contain only pertinent and important facts. Arrangements have been made to publish these in the same form as other scientific articles since the average reader shies from long articles in small type. The Publication Committee has authorized the allowance of one or two complimentary cuts to accompany these clinico-pathological conferences.

There has been a satisfactory response to the cartoons which it is hoped will be a regular feature of THE JOURNAL. Dr. C. L. A. Oden has been most kind in giving freely of his skill.

The Editor would like to end this report with a plea to the Councilors to forward to the Editor any comments which they may hear in their districts. It is very difficult to induce the readers to criticize by letter. Especially desirable are any suggestions which would make THE JOURNAL more readable, since a journal which is not read should not be published.

ROY HERBERT HOLMES, M.D., *Editor.*

The report was referred to the Publication Committee.

6. The *Report of the Publication Committee* was presented by the Chairman, Dr. Haughey.

REPORT OF THE PUBLICATION COMMITTEE—1940

Your Committee met January 10 and considered the following matters:

1. The Editor gave a report on the year's activities.

2. The *Journal Budget* was studied, and motion was made by Drs. DeGurse-Beck that this committee recommend to the Finance Committee that an increase in the Editor's Expense of $200.00 (from $600 to $800) be made. Carried unanimously.

3. *Advertising* was generally discussed. The committee felt that the acceptance of the AMA Councils and Committees on indicated products should be continued as a policy of THE JOURNAL, and authorized Mr. Burns, on motion of Drs. DeGurse-Umphrey, to so inform particular firms which were prospective advertisers. Carried unanimously.

4. *Reprints.*—The request of a firm for permission to make reprints of an article which appeared in the MSMS JOURNAL was studied. This firm is not an advertiser. Motion of Drs. Beck-Perkins that the matter be referred to Mr. Burns to handle—to the effect that permission to make reprints of MSMS JOURNAL articles is given only to authors, and to advertisers when specifically authorized by the Publication Committee. Carried unanimously.

5. *Blue Book.*—The Wisconsin Blue Book, and the high expense involved in the printing of this legal summary, were discussed. Motion of Drs. DeGurse-Beck that such a blue book for Michigan be not authorized at this time, as much of the material is being published in digested form in the MSMS JOURNAL in the "You and Your Business" column. Carried unanimously.

6. *Matters presented by the Editor:*

(a) Tuberculosis Abstracts, to be used as fillers in THE JOURNAL, were discussed, and authorized. They are to be used for a limited time to ascertain if there is any interest.

(b) Color for THE JOURNAL was discussed. Motion of Drs. DeGurse-Perkins that green pages be used in the March, 1941, JOURNAL, as an experiment. Carried unanimously.

(c) Column for experimental work. This was given full study and was authorized by the Publication Committee.

Respectfully submitted,

WILFRID HAUGHEY, M.D., *Chairman.*
O. O. BECK, M.D.
T. E. DEGURSE, M.D.
ROY C. PERKINS, M.D.
C. E. UMPHREY, M.D.

The report was referred to The Finance Committee.

7. *Report of Medical Legal Cases* pending was presented by Dr. Hyland, received and placed on file, on motion of Drs. Riley-Cummings. Carried unanimously.

8. *Committee Reports.*—The following reports of committees were presented:

(a) *Legislative Committee.*—Report from Executive Secretary Burns. The various items, including necessary amendments to the afflicted child act, were thoroughly discussed. Motion of Drs. Moore-DeGurse that a committee be appointed to review the various recommendations made and to refer back to The Council at its meeting on January 12. Carried unanimously.

Committee: Drs. Moore, Chairman; Cummings, Haughey, Carstens, Urmston.

Motion of Drs. DeGurse-Sladek that the report of the Legislative Committee be accepted and approved. Carried unanimously.

(b) *Midwifery (from Maternal Health Committee report).*—The case of People vs. Hildy was presented by the Executive Secretary and thoroughly discussed. Motion of Drs. Cummings-Barstow that this matter be referred to the MSMS Legislative Committee to send to the State Board of Registration in Medicine with the suggestion that the State Board consider and take action toward necessary changes in the Medical Practice Act to clarify this midwifery problem. Carried unanimously.

Field representatives in obstetrics (from Maternal Health Committee) were discussed by Dr. Cummings, who felt that this work should be educational, not practicing or doing private consultations. The Secretary was instructed to insert in letters going to county medical societies scheduling field representatives in obstetrics a paragraph containing the above recommendation.

(c) *Committee on NYA Health Program.*—This report was presented and discussed. Motion of Dr. Holmes-several that NYA Health Consultant Carey be requested to send detailed information concerning procedures and the per diem arrangement, in order that these facts can be presented concisely to the county medical societies; also to send a copy of the fee schedule to be used in those counties too small to use the per diem arrangement. Carried unanimously.

Dr. Umphrey advised that the Michigan Society of Roentgenologists objected to the x-ray phase of the NYA program. This was thoroughly discussed, during which Dr. Urmston presented the x-ray arrangement at Hurley Hospital, Flint. Motion of Drs. Cummings-Umphrey that The Council endorses the attitude of the x-ray society but inasmuch as the subject is technical and a matter of economics, it recommends the X-Ray Society contact Dr. Carey direct, in order that the problem can be more readily appreciated. Carried unanimously.

(d) *Postgraduate Medical Education Committee.*—Report was presented by Dr. Cummings, and approved on motion of Drs. Riley-Holmes. Carried unanimously.

President Urmston's appointments of Drs. Norris and Pino to the Postgraduate Medical Education Committee were confirmed, on motion of Drs. Huron-Cummings. Carried unanimously.

(e) *Preparedness Committee* report was read, containing the recommendation that letters be sent to all physicians who have not returned their AMA medical preparedness questionnaires. Motion of Drs. Holmes-Riley that lists of the non-signers be sent to the medical preparedness committee in each county or district for personal contact, except Wayne County. Carried unanimously. Motion of Drs. Haughey-Cummings that individual letters be sent to physicians in Wayne County who have not completed their questionnaires. Carried unanimously. Motion of Drs. DeGurse-Huron that the report of the Preparedness Committee, as amended in the matter of sending out the letters, be adopted. Carried unanimously.

9. *Voluntary Liens in Accident Cases.*—The Executive Secretary was invited to give a report on this activity which culminated successfully in adoption of an agreement on January 8, 1941. Motion of Drs. DeGurse-Barstow that this agreement be approved and adopted by The Council and be published in the MSMS JOURNAL. Carried unanimously. Motion of Drs. Haughey-Holmes that Dr. A. S. Brunk be appointed as the MSMS representative to the Conference Committee. Carried unanimously. Motion of Drs. Cummings-Riley that the Executive Secretary be thanked for the inauguration and development of this project. Carried unanimously.

Presentation of Gavel to the Chairman.—A gavel was presented to Council Chairman Brunk by Executive Secretary Burns as an expression of his appreciation of Dr. Brunk's counsel during the past eleven years.

The meeting was recessed at 12:10 p.m.

SECOND SESSION

The Second Session convened at 1:30 p.m., with all who answered to the roll call at the First Session being present.

10. *Communications from the Wayne County Medical Society* re (a) the barbiturates bill to include sulfanilamide; and (b) amendments to the Medical Practice Act, were presented and discussed. Motion of Drs. Umphrey-Riley that The Council urges the State Board of Registration in Medicine to offer necessary amendments to the Medical Practice Act at the 1941 Legislative Session, and it urges the State Health Commissioner to offer a barbiturates bill, including the sulfanilamide group to the 1941 Legislature, the aid of the MSMS Legislative Committee being proffered to these two state departments in the passage of these bills. Carried unanimously.

11. *Additional Michigan Facilities for Care of Infantile Paralysis Cases.*—Dr. Barstow presented a project for the care of these cases in Michigan, which was thoroughly discussed and referred to a committee composed of the Chairman of The Council, the Secretary and the Executive Secretary to draft a suitable resolution and to submit same to The Council for final approval.

Subsequently the Committee presented the following resolution:

"Whereas, Large sums of money are being collected in Michigan each year for the care and treatment of infantile paralysis cases,

"Be It Resolved, That The Council of the Michigan State Medical Society approves of the establishment in the state of additional special facilities for the care and treatment of such cases."

Motion of Drs. Riley-Miller that the report of the committee be adopted. Carried unanimously.

12. *Preparedness Committee.*—The matter of the personnel of the Medical Preparedness Committee of the State Society was discussed and, on motion of Drs. Holmes-Moore, laid on the table until the Midsummer meeting of The Council. Carried unanimously.

M.M.S. PROGRESS REPORT

13. *Michigan Medical Service.*—Dr. Carstens gave a progress report as follows, which was accepted and placed on file, on motion of Drs. Sladek-Perkins. Carried unanimously.

Enrollment of Subscribers

The following is the cumulative number of persons enrolled:

Month	Plan Medical Service	Plan Surgical Benefit	Total Enrollment
March	1,360	58,658	60,118
April	1,341	60,368	61,709
May	1,352	61,783	63,135
June	1,416	63,646	65,062
July	1,594	65,388	66,982
August	1,700	65,749	67,449
September	1,758	67,558	69,316
October	4,346	86,050	90,396
November	4,677	99,243	103,920
December	4,956	112,594	117,550

Registration of Doctors

The number of physicians who have registered with Michigan Medical Service has increased steadily. As of November 30, 1940, there were 3,321 doctors of medicine registered with Michigan Medical Service—approximately three-fourths of the total possible number.

In two county medical societies, 100 per cent of the members are registered with Michigan Medical Service and in thirty-two others, from 75 per cent to 99 per cent of the members are registered.

Services and Payments to Doctors

During the past nine months, 4,625 subscribers have received services through Michigan Medical Service for which 1,337 doctors of medicine will receive in excess of $194,000.

Payments have been made to doctors in 70 of the 83 counties in Michigan and one out of every four doctors has been paid through Michigan Medical Service for services to subscribers.

The average payment for a patient under the Surgical Benefit Plan has been $47.11; for a patient under the Medical Service Plan, $16.27; or an average of $38.89 per patient.

14. *Reports of Individual Councilors.*—The Chair called upon each Councilor to give a report of the condition of the profession in his district. These reports were given verbally and were generally to the effect that the profession is working together harmoniously and making good progress in scientific and social endeavor.

The meeting was recessed at 3:50 p.m.

THIRD SESSION

The Third Session Convened at 8 p.m. with all who answered the roll call at the First Session being present.

15. *The Auditor's Report* was presented in brief by Dr. Moore, who also read the minutes of the Finance Committee meeting of January 10, 1941, including MSMS Budgets for 1941.

REPORT OF THE FINANCE COMMITTEE

Your Committee met January 10 and considered the following matters:

1. *Auditor's Report.*—Chairman Moore reviewed the report of Ernst & Ernst's annual audit of the Society's books for 1940.

2. *Net Worth.*—Motion of Drs. Morrish-Cummings that the net worth of the Society should not exceed at any time $50,000. Carried unanimously.

3. Motion of Drs. Cummings-Barstow that $7,500 be invested in U. S. Government bonds, preferably U. S. Savings Bonds. Carried unanimously.

4. *Budget.*—The proposed 1941 budget was considered by the Committee. Motion of Drs. Morrish-Cummings that the Committee recommended that the salary of the Executive Secretary be set at $8,000. Carried unanimously. The tentative budget was then agreed upon for presentation to The Council.

VERNOR M. MOORE, M.D., *Chairman.*
W. E. BARSTOW, M.D.
H. H. CUMMINGS, M.D.
R. S. MORRISH, M.D.
O. D. STRYKER, M.D.

BUDGET FOR 1941

INCOME	
4,200 members at $12 (plus ½ and ¼ dues of new members)	$51,000.00
Net Income from JOURNAL	
Interest	100.00
Miscellaneous Income	100.00
Total Income	$51,200.00
Less allocation to THE JOURNAL at $1.50	6,300.00
NET INCOME	$44,900.00
APPROPRIATIONS:	
Administrative and General	
Medical Secretary Salary	$ 3,600.00
Executive Secretary Salary	8,000.00
Other Office Salaries	5,100.00
Extra Office Help	1,020.00
Office Rent	1,260.00
Printing, Sta. & Supplies	1,000.00
Postage	900.00
Insurance and Fidelity Bonds	190.00
Auditing	265.00
New Equipment and Repairs	300.00
Telephone and Telegraph	800.00
Michigan Sales Tax	75.00
Pay roll taxes	154.00
Miscellaneous	250.00
Total	$22,914.00
Less expenses redistributed to JOURNAL	1,800.00
TOTAL ADMINISTRATION AND GENERAL	$21,114.00
Public Relations Bureau (authorized by 1940 House of Delegates):	
Salary	$ 2,400.00
Travel	400.00
Stenographic Service	600.00
Office Expense	500.00
TOTAL FOR PUBLIC RELATIONS BUREAU	$ 3,900.00
Society Expense	
Council Expense	$ 3,000.00
Delegates to AMA	500.00
Secretaries Conferences	1,000.00
General Society Travel Exp.	2,000.00
Secretary's Letters	500.00
Publication Expense	200.00
Reporting Annual Meeting	140.00
Education Expense	2,000.00
Sundry Society Expenses	1,200.00
National Conf. on Medical Service	200.00
Organizational Expense	1,000.00
Legal Expense	500.00
Woman's Auxiliary—Annual Meeting	200.00
Contingent Fund	766.00
Total	$13,206.00
Less gain from Annual Meeting	2,320.00
TOTAL SOCIETY EXPENSE	$10,886.00
Committee Expense	
Legislative Committee	$ 2,000.00
Distribution of Medical Care	150.00
Joint Committee on Health Education	850.00
Postgraduate Education	2,400.00
Preventive Medicine	200.00
Cancer Committee	1,000.00
Child Welfare	250.00
Iodized Salt	100.00
Heart & Degenerative Diseases	100.00
Industrial Health	200.00
Maternal Health	100.00
Mental Hygiene	50.00
Radio	25.00
Syphilis Control	325.00
Tuberculosis Control	100.00
Public Relations Committee	500.00
Ethics Committee	100.00
Scientific Work Committee	200.00
Medical Preparedness	100.00
Sundry Other Committees	250.00
TOTAL COMMITTEE EXPENSE	$ 9,000.00
GRAND TOTAL	$44,900.00

BUDGET FOR THE JOURNAL, 1941

INCOME	
Subscription from members	$ 6,300.00
Other subscriptions	200.00
Advertising Sales	10,000.00
Reprint Sales	1,500.00
Journal cuts	150.00
TOTAL JOURNAL INCOME	$18,150.00
EXPENSES	
Editor's Salary	$ 1,200.00
Editor's Expense	800.00
Expense of prior year	
Printing and mailing	11,300.00
Cost of reprints	1,500.00
Allocation of administrative and general office expense	1,800.00
Discounts and commissions on advertising sales	1,300.00
Postage	2.50.00
TOTAL JOURNAL EXPENSE	$18,150.00

Motion of Drs. DeGurse-Sladek that the budgets as presented be adopted. Carried unanimously. Motion of Drs. Moore-Huron that the Finance Committee report be adopted. Carried unanimously.

Bills payable were presented and ordered paid on motion of Drs. Perkins-DeGurse. Carried unanimously.

16. The *Report of County Societies Committee* including the *Reference Report* was presented by Dr. Sladek.

REPORT OF THE COUNTY SOCIETIES COMMITTEE

Your Committee met January 10 and considered the following matters:

1. The Committee reviewed the list of twenty-three counties which have not sent in the resolution calling for a thirty-year extension of the Charter of the Michigan State Medical Society, and recommend that the Councilors contact each Society in their respective Districts which have not sent in the resolution, urging them to do so as soon as possible.

2. The recommendation of the Radio Committee to the House of Delegates, 1940, which was approved by the House, and which is as follows: "That the State Society and/or the Joint Committee on Health Education set up some method for evaluation of the radio programs, and that some effort should be made to coordinate the radio programs on medical subjects now being broadcast by the U. of M., Wayne County Medical Society, and those sponsored by the Joint Committee on Health Education so as to avoid overlapping and repetition," was studied by the Committee. It was suggested that the Councilors contact their various societies with a view to determining the relative value of the radio programs. The Committee also recommends that the County Societies endeavor to develop or select speakers to present talks over the radio which will impress their audiences.

3. In accordance with the suggestion in President Corbus' address at the 1940 annual meeting: The County Societies Committee agrees that some effort should be made to stimulate the writing of scientific articles by our membership and recommends that each Councilor constantly stress this endeavor at his visits to his County Medical Societies.

4. Postgraduate Medical Education. In an effort to stimulate more interest in the Postgraduate courses we would recommend that the Postgraduate Medical Education Committee send out a questionnaire to all members relative to subject matter of future postgraduate courses. It is possible that a more acceptable subject matter will react in better attendance.

We would also like to suggest to the Postgraduate Committee the possibility of holding one large all-day conference given by more outstanding lecturers instead of the four weekly meetings.

In view of the possible examination for certification of proficiency to be given by our two state universities we believe it advisable to publish a list of subjects which were covered in the previous four years. We feel that these examinations are a commendable addition to the postgraduate program, resulting in a certificate which will have a definite meaning.

5. We recommend that some study be instituted at this time relative to school athletic examinations and treatment of injured students.

E. F. SLADEK, M.D., *Chairman.*
WILFRID HAUGHEY, M.D.
P. A. RILEY, M.D.
W. H. HURON, M.D.
A. H. MILLER, M.D.

REFERENCE REPORT OF COUNTY SOCIETIES COMMITTEE

1. *Secretary's Report*—(A) The Committee recommends that remission of 1941 dues for service men be limited to those who have been certified by County Society Secretary as being in good standing as of January 1, 1941, and that a form be printed in THE JOURNAL for the county secretaries' use.

(B) We recommend the acceptance of the Secretary's Report in its entirety, noting that this year it exhibits the same thoroughness and clarity of analysis of Society affairs, as it has in the past. We heartily commend our Secretary for his zeal and diligence.

E. F. SLADEK, M.D., *Chairman.*

REFERENCE REPORT OF PUBLICATION COMMITTEE

Motion of Drs. Sladek-Huron that the reports be adopted was carried unanimously.

17. *Reference Report of Publication Committee* was presented by Dr. Haughey to the effect that the Editor's Report was received and the Editor was thanked for his good work and the progress of THE JOURNAL during the past year. Motion of Drs. Riley-Moore that the report of the Reference Committee be adopted. Carried unanimously.

18. *Executive Secretary to West Virginia.*—The Council approved Mr. Burns' appearing on the program of the West Virginia Medical Society Secretary Conference, January 18, on motion of Drs. Sladek-Miller. Carried unanimously.

19. *Medical Testimony.*—The Executive Secretary presented the recent Supreme Court case of DeVries vs. Owens.

The meeting was recessed at 10:05 p.m.

FOURTH SESSION

The Fourth Session convened at 10:15 a.m. January 12, 1941, with all who answered to the roll call at the First Session being present.

20. *Minutes.*—The minutes of the First, Second and Third Sessions of The Council, January 11, 1941, were read, corrected and approved.

REFERENCE REPORT OF FINANCE COMMITTEE

21. *Reference Report of Finance Committee.*—Chairman Moore reported as follows:

(a) Treasurer's Report. This report was studied by the committee and accepted with the exception of the last line which was changed to read "Total funds in my possession as Treasurer of the MSMS including bonds at quoted market prices are $22,811.25 and cash in Michigan National Bank $707.59 totalling $23,518.84." Motion of Drs. Sladek-Miller that the report be accepted. Carried unanimously.

(b) Trustee Hyland's Report. The committee approved of this report. Motion of Drs. Cummings-Sladek that this report be accepted. Carried unanimously.

(c) Publication Committee Report was approved. Motion of Drs. Moore-Cummings that this report be accepted. Carried unanimously. Motion of Drs. Moore-Cummings that the Reference Committee Report be accepted as a whole. Carried unanimously.

REFERENCE REPORT OF AFFLICTED CHILD LAW AMENDMENTS

22. *Report of Committee on Amendments to Afflicted Child Law.*—Chairman Moore reported as follows: The following principles were recommended:

1. Personnel of Commission should be selected on basis of knowledge, interest and ability. Because this is largely a medical problem, at least one doctor of medicine should be appointed to the Commission.

2. The Administrator should be a doctor of medicine. If a business manager is needed, he should be an assistant under the medical administrator.

3. The Commission should be designed the "Sick Child Commission." All sick children, whether crippled or afflicted, should come under this one commission.

4. Five medical coördinators to integrate the work of the Commission throughout the state should be provided.

5. Medical Filter Boards, nominated by the county medical societies and paid a nominal fee by the Commission for investigation work, to coöperate with the medical coördinators, should be arranged. The power of admission and/or rejection of cases, either on medical or economic grounds, should be in the hands of the Commission.

6. Cases needing special medical care should be delegated by the medical administrator to the medical coordinator to refer to doctors of medicine possessing the necessary skill. Cases which do not need special treatment should be cared for by local family doctor. Cases should be transferred from the general to the special group as circumstances demand.

7. The medical coördinator should decide the degree of economic filtering, using the facilities of established fact-finding agencies in this work. The Sick Child Commission should determine the economic level of cases to come within the jurisdiction of the Commission. Service to be rendered by the Commission to be limited to the funds available, on the basis of need. Hospital stay to be determined by the attending doctor, with the advice of the medical coördinator in unusual cases.

8. Rates and fee schedules for hospitals and doctors to be arrived at by conference between the Commission and interested groups.

The report was discussed generally by those present. It was pointed out that in drafting a new law, three possibilities should be kept in mind, (1) the project could be wholly in the hands of the state; (2) it could be a jointly financed affair between the respective counties and the state, or (3) it could be transferred to the State Welfare Commission. Discussion brought out that the afflicted child should be administered exclusively by the state, rather than dividing the responsibility between the state and the eighty-three counties and thus running into eighty-three methods of handling the situation. Objections to the plan whereby the afflicted children law administration would be transferred to the State Welfare Department were summarized as follows: (1) Earmarked money is necessary —not what is left over *after* food, clothing, fuel, shelter have been provided. Neglect will result just as neglect now exists in welfare cases in certain counties particularly where they have the 15 mill tax limitation. (2) Problem of the sick child is separate and distinct from the problem of relief—40 per cent of the afflicted children are not on relief, but come from the borderline group. (3) The Welfare Department must limit its work to *indigents*. (4) There would be as many types of social welfare programs as there are counties.

The difficulty of providing for the regular needs of medical care of afflicted children, and particularly in case of epidemics, was discussed. It was also pointed out that the acute emergency case should be taken care of by the county; that the afflicted child law should take care of those chronic conditions which can be readily remedied, thus bring the child back to good health and insure their becoming healthy self-supporting citizens. Dr. Cummings stated that there should be at least one medical man on the Commission, plus a medical man as administrator, plus 5 to 7 medical coördinators.

Motion of DeGurse-Moore that the recommendations of the special committee on afflicted child amendments be approved. Motion of Drs. Umphrey-DeGurse that the above motion be amended as follows: and in addition that the present committee of The Council plus the Child Welfare Committee of the MSMS be empowered to contact the proper agencies for the drafting of the proposed bill. The amendment was carried unanimously. The main motion was then put and carried unanimously.

The Council felt that if it became probable that the afflicted child were to be placed under the State Welfare Department, the afflicted child should be divided into two groups: 1. emergency cases, to be paid for by the county; and 2. chronic remedial cases to be paid for by the State.

23. *Preventive Medicine Committee* report was given by the Executive Secretary: The recommendation of the Cancer Committee that one half of the additional expense of Frank Power, M.D., Field Representative in Cancer, be paid by the MSMS out of the Cancer Committee budget (the other half to be paid by the State Health Department) was approved on motion of Drs. Huron-Umphrey. Carried unanimously. The recommendation of the Cancer Committee that a bill be drafted which would provide for a cancer control program in Michigan was discussed. The Council felt that the Cancer Committee might well draft such a bill to be presented to the Michigan Legislature by some such agency as the Women's Field Army or the State Health Department.

24. *Recommendations of Past-President Corbus,* made in his President's Address, (a) that the young medical graduate be encouraged to join organized medicine by offering him reduced dues, and (b) that a committee on Prelicensure Education be named with additional representation from the State Board of Registration in Medicine and the Michigan Hospital Association, the objective of which is to develop a coöperative plan for intern training, were presented. Motion of Drs. Holmes-Haughey that the Chairman of The Council appoint a committee to investigate the possibility of carrying out these suggestions. Carried unanimously.

25. *Election of Secretary.*—Motion of Dr. Haughey-several that L. Fernald Foster, M.D., be elected secretary to succeed himself. Carried unanimously.

26. *Election of Treasurer.*—Motion of Dr. Perkins-several that Wm. A. Hyland, M.D., be elected treasurer to succeed himself. Carried unanimously.

27. *Election of Editor.*—Motion of Dr. Haughey-several that Roy Herbert Holmes, M.D., be elected editor to succeed himself. Carried unanimously.

28. *Appointment of Executive Secretary.*—Motion of Dr. Umphrey-several that Wm. J. Burns be appointed to succeed himself. Carried unanimously.

29. *Regrets.*—The Council on motion of Dr. Perkins-several extended the sincere regrets of those present to Councilors Hubbell and Stryker on their inability to attend the 1941 Midwinter session, and to Councilor Morrish who was ill and confined to his room at the Dearborn Inn. Carried unanimously.

30. *Thanks.*—Chairman Brunk expressed his thanks to the members of The Council for their attention, hard work and coöperation. Dr. Moore, in behalf of the members of The Council, commended the Chairman on his excellent and smooth handling of the affairs during the session.

31. *Adjournment.*—The meeting was adjourned at 12:05 p.m.

REPORT OF AUDITOR FOR 1940

January 4, 1941

Executive Committee of the Council,
Michigan State Medical Society,
Lansing, Michigan.

We have examined the balance sheet of the Michigan State Medical Society as of December 21, 1940, and the statements of income and expense for the fiscal year ended at that date, have reviewed the system of internal control and the accounting procedures of the Society and, without making a detailed audit of the transactions, have examined or tested accounting records of the Society and other supporting evidence, by methods and to the extent we deemed appropriate.

The Society was organized under the laws of the State of Michigan on September 17, 1910, as a corporation not for pecuniary profit. Action has been taken to renew the charter which expired by lapse of time prior to December 21, 1940. The Society is affiliated with the American Medical Association and charters county medical societies within the State of Michigan. The purposes of the Society are the promotion of the science and art of medicine, the protection of the public health and the betterment of the medical profession. In the furtherance of these purposes, the Society publishes THE JOURNAL OF THE MICHIGAN STATE MEDICAL SOCIETY.

Balance Sheet

A summary of the balance sheets at December 21, 1940, follows:

ASSETS

Cash	$15,142.96
Notes and accounts receivable, less reserve	1,237.49
Securities—at cost, less reserve	22,811.25
Deferred charges	22.70
	$39,214.40

LIABILITIES

Accounts payable	$ 352.27
Unearned income	1,073.50
Net worth	37,788.63
	$39,214.40

Notes receivable in the amount of $80.00, which had been accepted in settlement of 1931, 1932, and 1933 dues were written off during the year as uncollectible.

Accounts receivable for advertising, reprints, etc., were analyzed and classified as to date of charge and are shown with the balances at December 21, 1940, as follows:

DATE OF CHARGE	Amount	Per Cent
October, November and December	$ 857.96	78.86%
July, August and September	142.88	13.13%
January to June, inclusive	63.14	5.80%
Prior to January 1st	24.00	2.21%
TOTAL	$1,087.98	100.00%

The balances due from county societies represent dues collected for the Society by two county societies and impounded in depositary banks. When and if any of these funds are released by the banks, the Society's share is to be forwarded by the county societies. No payments were received during the year on these accounts.

Based upon our analysis of the accounts receivable and a discussion of their collectibility with employes of the Society, it is our opinion that the reserve of $175.00 is sufficient to provide for collection losses anticipated at the date of this report.

During the year it was determined that the Society was subject to the Federal Insurance Contribution Act with respect to salaries paid to employes since January 1, 1937. The employes' share of the contributions for the period from January 1, 1937, to June 30, 1940, have been charged to them and they are paying the Society over a period of twenty months. The tax is now being paid currently and the employes' shares are being deducted from salary checks.

A schedule of securities owned is included elsewhere in this report, which sets forth the principal amount, cost and quoted market prices at December 21, 1940. Unlisted securities have been valued from information furnished by brokers as to the current bid and sale prices. Securities in the principal amount of $9,000.00, having aggregate quoted market prices of $6,000.00 as at December 20, 1939, were turned over to Dr. William A. Hyland, Trustee, in settlement of the Society's liability to him. Subsequently, bonds in the principal amount of $2,000.00 were purchased from Dr. Hyland at their approximate quoted market prices.

During the year, the Michigan Medical Service was formally incorporated and commenced operations. The Society advanced $10,000.00 for working capital, the liability for which had been provided for in the preceding year, and also paid certain expenses prior to the commencement of operations by the Michigan Medical Service. At December 21, 1940, the total of the advances to and expenditures for the Michigan Medical Service amounted to $17,544.45. We understand that these advances and expenditures are to be repaid to the Society only from earnings of the Michigan Medical Service with the permission of the Insurance Department of the State of Michigan. Because of the uncertainty of repayment of these items, a reserve has been provided for possible loss of the total amount of $17,544.45.

Deferred charges represent costs incurred prior to December 21, 1940, with respect to the 1941 annual meeting of the Society. In accordance with established policy, such items are properly chargeable to future operations.

Provision has been made for all ascertained liabilities at December 21, 1940.

Collections of 1941 dues and overpayments of dues for prior years have been shown as unearned income.

Income and Expense Statement

A summary of the income and expense statement for the fiscal year ended December 21, 1940, is presented in the accompanying schedule.

As in prior years, $1.50 of each member's annual membership fee has been allocated to subscription income of THE JOURNAL OF THE MICHIGAN STATE MEDICAL SOCIETY.

In the accompanying summary a comparison is shown of the budget adopted at the mid-winter council meeting for the year 1940 with the actual results of operations for the year.

As formally adopted, the budgets of operations of both the Society and THE JOURNAL show expenses equal to income. In the budget for THE JOURNAL, however, the amount of $1,856.25 is shown under expenses as "reserve." In order to show the combined budgets on the same basis as the income and expense statement, the amount of $1,856.25 has been classified in the accompanying schedule as income from THE JOURNAL.

Schedules are included herein showing the income from THE JOURNAL and the expenses of the Society in greater detail in comparison with the budgets of THE JOURNAL and of the Society for the year.

INCOME AND EXPENSE STATEMENT

INCOME

Membership fees	$46,174.02
Income from THE JOURNAL	2,740.96
Interest received	829.18
Miscellaneous	326.36
Total Income	$50,070.52

EXPENSES

Administrative and general	$19,909.71
Society activities	10,696.89
Committee expenses	5,518.64
Total Expenses	$36,125.24
Excess of Income over Expenses	$13,945.28
Other income	76.25
Net Income	$14,021.53
Adjustments to net worth account	457.25
Increase in Net Worth	$13,564.28

BUDGET

INCOME	
Membership fees	$45,543.75
Income from THE JOURNAL	1,856.25
Interest	100.00
Miscellaneous	75.00
Total Income	$47,575.00
EXPENSES	
Administrative and general	$19,390.00
Society activities	17,783.75
Committee expenses	8,545.00
Total Expenses	$45,718.75
Excess of Income over Expenses	$ 1,856.25
Other income	—o—
	$ 1,856.25
Adjustment to net worth account	—o—
Increase in Net Worth	$ 1,856.25

Examination Comments

The following comments relate to our examination and tests of the accounting records of the Society and other supporting evidence.

The demand and savings deposits were confirmed by correspondence with the depositary banks and by reconcilement of the balances reported by them to the amounts shown in the balance sheet. The office cash fund was counted on the morning of December 23, 1940. Bank deposits during three months of the year, as shown in the cash receipts book, were compared with the credits shown on the bank statements on file, and the monthly totals of bank deposits as shown in the cash receipts book where compared with the monthly totals of cash receipts as recorded therein. The recorded cash disbursements for three months of the year were compared with canceled bank checks, invoices and other memoranda. To the extent of the tests made, no irregularities were disclosed.

A listing of the individual accounts receivable was in agreement with the controlling account. In order to confirm the accuracy of the records, confirmation requests were mailed to certain debtors selected by us. To the extent of the replies received, no discrepancies were disclosed.

Securities were examined by us on the afternoon of December 21, 1940, and we obtained a certificate from the bank that the safety deposit box in which the securities are kept, was not opened subsequent to our examination and prior to December 23, 1940.

We secured a written confirmation of the account with the Michigan Medical Service.

We did not correspond with the recorded creditors of the Society for the purpose of confirming the liabilities at December 21, 1940; however, we examined unpaid invoices, expense reports, etc., received subsequent to that date, to satisfy ourselves that all liabilities had been provided for.

In addition to our examination of the items included in the balance sheet, we made tests of transactions entering into the income and expense accounts. Unused membership certificates were examined for the purpose of checking the income from dues. Interest income on bonds was accounted for. Tests of advertising income were made by comparison of billings for advertising with space used in three issues of THE JOURNAL. We also reviewed the items charged to the major expense accounts for the year.

Opinion

In our opinion, the accompanying balance sheet and related statements of income and expense present fairly the position of the Michigan State Medical Society at December 21, 1940, and the results of its operations for the fiscal year, in conformity with generally accepted accounting principles applied on a basis consistent with that of the preceding year.

ERNST & ERNST,
Certified Public Accountants.

BALANCE SHEET

December 21, 1940

ASSETS				
Cash				
Demand deposits			$ 2,919.56	
Office cash fund			9.28	
Savings deposits			12,214.12	$15,142.96
Accounts Receivable				
For advertising, reprints, etc.	$1,087.98			
From county societies for dues	75.19	$ 1,163.17		
Less reserve		175.00	$ 988.17	
From officers and employees for pay roll taxes of prior years.			249.32	1,237.49
Securities				
Bonds and stock—at cost			$26,717.25	
Less reserve to reduce to aggregate quoted market prices			3,906.00	22,811.25
Michigan Medical Service				
Organizational expenditures made by the Michigan State Medical Society		$ 7,544.45		
Advance for working capital		10,000.00	$17,544.45	
Less reserve			17,544.45	—o—
Deferred Charges				
Expenses in connection with 1941 annual meeting				22.70
				$39,214.40
LIABILITIES				
Accounts Payable				
For current expenses, etc.			$ 311.09	
Pay roll taxes			41.18	$ 352.27
Unearned Income				
Dues for the year 1941				1,073.50
Net Worth				
Balance at December 21, 1939			$24,224.35	
Net increase for the fiscal year ended December 21, 1940			13,564.28	37,788.63
				$39,214.40

INCOME AND EXPENSE STATEMENT

Fiscal year ended December 21, 1940

INCOME:		
Membership fees	$52,770.00	
Less portion allocated to income of THE JOURNAL for subscriptions	6,595.98	$46,174.02
Income from THE JOURNAL—as shown by schedule		2,740.96
Interest received		829.18
Miscellaneous		326.36
Total Income		$50,070.52
EXPENSES—AS SHOWN BY SCHEDULE:		
Administrative and general	$19,909.71	
Society activities	10,696.89	
Committee expenses	5,518.64	36,125.24
Excess of Income over Expenses		$13,945.28
OTHER INCOME:		
Reduction in reserve for notes and accounts receivable	$ 70.00	
Profit on sale of securities	6.25	76.25
Net Income		$14,021.53
ADJUSTMENT TO NET WORTH:		
Increase in reserve to reduce securities owned to quoted market prices		457.25
Increase in Net Worth		$13,564.28

INCOME FROM "THE JOURNAL OF THE MICHIGAN STATE MEDICAL SOCIETY"

Fiscal year ended December 21, 1940

INCOME

Subscriptions from members	$ 6,595.98
Other subscriptions	122.50
Advertising sales	10,982.87
Reprint sales	2,120.23
Journal cuts	170.16
	$19,991.74

EXPENSES

Editor's salary	$ 1,200.00
Editor's expense	600.00
Expense of prior year	400.00
Printing and mailing	9,989.06
Cost of reprints	1,765.90
Allocation of administrative and general expense	1,800.00
Discounts and commissions on advertising sales	1,245.82
Postage	250.00
	$17,250.78
Net Income	$ 2,740.96

EXPENSES

Fiscal year ended December 21, 1940

ADMINISTRATIVE AND GENERAL

Salary of Medical Secretary	$ 3,600.00
Salary of Executive Secretary	7,000.00
Other office salaries	5,100.00
Extra office help	480.00
Office rent	1,235.00
Printing, stationery and supplies	1,019.65
Postage	865.30
Insurance and fidelity bonds	187.28
Auditing	265.00
New equipment and repairs	137.42
Telephone and telegraph	796.70
Sales tax	30.06
Pay roll taxes—current year	127.15
Pay roll taxes—prior year	522.53
Pay roll taxes—interest and penalties	326.62
Miscellaneous	17.00
	$21,709.71
Less expense redistributed to THE JOURNAL	1,800.00
	$19,909.71

EXPENSES

(Continued)

SOCIETY ACTIVITIES

Council expense	$ 4,176.78
Delegates to American Medical Association	887.65
Secretaries' conferences	944.11
General society traveling expense	2,197.14
Secretary's letters	217.20
Publication expense	2.50
Reporting annual meeting	135.75
Michigan Medical Service	783.77
Educational expenses	1,000.00
National Conference on Medical Service	242.53
Organizational expenses	—o—
Legal expense	710.15
Woman's Auxiliary—annual meeting	200.00
Sundry society expenses	1,163.15
Contingencies	—o—
	$12,660.73
Less revenue from annual meeting in excess of cost thereof	1,963.84
	$10,696.89

COMMITTEE EXPENSES

Legislation committee	$ 258.27
Committee on distribution of medical care	131.56
Contribution to joint committee on health education	800.00
Preventive medicine committee	41.60
Cancer committee	888.83
Child welfare committee	217.06
Iodized salt committee	24.57
Heart and degenerative diseases committee	134.38
Industrial health committee	186.43
Maternal health committee	99.91
Mental hygiene committee	50.00
Radio committee	—o—
Syphilis control committee	296.85
Tuberculosis control committee	—o—
Public relations committee	102.71
Ethics committee	4.65
Membership committee	4.55
Advisory committee to Woman's Auxiliary	4.27
Scientific work committee	166.24
Postgraduate medical education	2,041.18
Sundry other committees	65.58
Committee reserve	—o—
	$ 5,518.64
Total	$36,125.24

COUNTY SECRETARIES CONFERENCE HELD JANUARY 19

Secretaries from thirty-nine county medical societies of Michigan met in Lansing on January 19 for their Annual Conference. Represented also in the total registration of 123 were forty-five health officers, four presidents of county medical societies, five officers and councilors and twenty-five guests.

The secretaries were welcomed by Hewitt Smith, M.D., Lansing, immediate past president of the Ingham County Medical Society. The morning program, presided over by Horace Wray Porter, M.D., of Jackson, included discussions by Secretary L. Fernald Foster, M.D., President-elect Henry R. Carstens, M.D., Colonel Harold A. Furlong, M.D., Medical Board, State Selective Service Headquarters; H. VanY. Caldwell, Executive Secretary of the Cleveland Academy of Medicine; and Harold A. Miller, M.D., Chairman of the MSMS Legislative Committee.

The health officers joined the secretaries for dinner and the afternoon program, at which President P. R. Urmston, M.D., presided. Mr. Joseph H. Creighton, Director of the Intangibles Tax Division of the Michigan State Tax Commission, reviewed the provisions of the Intangibles Tax Law, with particular emphasis on its effect on physicians. Talks were given by Kenneth E. Markuson, M.D., W. C. C. Cole, M.D., T. M. Koppa, M.D., and L. W. Shaffer, M.D., after which general discussion was led by Carleton Dean, M.D., Deputy State Health Commissioner.

E. B. Andersen, M.D., Iron Mountain, Secretary of the Dickinson-Iron County Medical Society was elected as Chairman of the Secretaries for the coming year.

Among those present were:

County Society Secretaries.—H. Kessler, M.D., Alpena; A. B. Gwinn, M.D., Barry; L. Fernald Foster, M.D., Bay; Richard C. Crowell, M.D., Berrien; Wilfrid Haughey, M.D., Calhoun; T. Y. Ho, M.D., Clinton; E. B. Andersen, M.D., Dickinson-Iron; B. P. Brown, M.D., Eaton; John S. Wyman, M.D., Genesee; Sara Burgess, Genesee; E. S. Oldham, M.D., Gratiot-Isabella-Clare; A. W. Strom, M.D., Hillsdale; Roy R. Gettel, M.D., Huron; R. J. Himmelberger, Ingham; J. J. McCann, M.D., Ionia-Montcalm; Horace Wray Porter, M.D., Jackson; Frank L. Doran, M.D., Kent; H. M. Best, M.D., Lapeer; Esli T. Morden, M.D., Lenawee; H. C. Hill, Livingston; D. Bruce Wiley, M.D., Macomb; C. L. Grant, M.D., Manistee; W. S. Jones, M.D., Menominee; H. H. Gay, M.D., Midland; Florence Ames, M.D., Monroe; C. G. Clippert, M.D., North Central Counties; A. F. Litzenburger, M.D., Northern Michigan; John S. Lambie, M.D., Oakland; R. J. Shale, M.D., Ontonagon; D. C. Bloemendaal, M.D., Ottawa; R. S. Ryan, M.D., Saginaw; J. H. Burley, M.D., St. Clair; J. W. Rice, M.D., St. Joseph; E. W. Blanchard, M.D., Sanilac; R. J. Brown, M.D., Shiawassee; Willard W. Dickerson, M.D., Tuscola; J. W. Iseman, M.D., Van Buren; R. K. Ratliff, M.D., Washtenaw; Gaylord S. Bates, M.D., Wayne; J. A. Bechtel, Wayne County Medical Society; B. A. Holm, M.D., Wexford-Missaukee.

County Society Presidents.—G. B. Saltonstall, M.D., Northern Michigan; Allan McDonald, M.D., Wayne; C. A. E. Lund, M.D., Barry; J. Bates Henderson, M.D., Huron.

Councilors.—A. S. Brunk, M.D., Wayne; W. E. Barstow, M.D., Gratiot; Roy C. Perkins, M.D., Bay.

Health Officers.—T. E. Gibson, M.D., A. D. Aldrich, M.D., Carleton Dean, M.D., E. R. VanderSlice, M.D., Paul A. Lindquist, M.D., John Monroe, M.D., Robert F. Van, M.D., S. E. Moore, M.D., Helen Lanting, M.D., R. Lanting, M.D., Lillian R. Smith, M.D., G. B. Moffat, M.D., George Hays, M.D., Emily Ripka, M.D., Goldie B. Corneliuson, M.D., Marie Hagele, M.D., A. B. Mitchell, M.D., Sue Thompson, M.D., Clifton Hall, M.D., Berneta Block, M.D., L. W. Switzer, M.D., C. D. Barrett, M.D., F. T. Andrews, M.D., E. V. Thiehoff, M.D., C. H. Benning, M.D., Frank A. Poole, M.D., Fred O. Tonney, M.D., F. R. Town, M.D., E. J. Brenner, M.D., Lawrence A. Berg, M.D., L. V. Burkette, M.D., Albert C. Edwards, M.D., J. K. Altland, M.D., M. R. Kinde, M.D., V. K. Volk, M.D., H. E. Cope, M.D., Edwin H. Place, M.D., Charles A. Neafie, M.D., K. Haitinger, M.D., L. A. Potter, J. P. Gray, M.D.

Guests.—George W. Cooley, Russell J. Darling, John A. MacLellan, J. D. Laux, Otis F. Cook, Harry R. Lipson, Frank G. Lark, C. K. Valade, M.D., Campbell Harvey, M.D., F. E. Luton, M.D., Milton Shaw, M.D., F. E. Reeder, M.D., Frank VanSchoick, M.D., T. Heavenrich, M.D., I. W. Green, M.D., Dean W. Myers, M.D., Henry Cook, M.D., K. L. Burt, M.D.

THE HUMAN MECHANISM AND THE SUBMARINE

Because the submarine, especially under conditions of warfare, imposes certain environmental conditions not inherent on surface ships, medical problems of a particularly difficult nature develop in the care of the personnel. Recently Brown† has reviewed some of the problems faced by the medical officers responsible for the care of men on this exacting duty. First the selection of men must be especially rigid and the criteria must include strong eyes, keen hearing and the ability to equalize air pressure of 50 pounds to the square inch on the ear drum, since this quality is essential in escape training with the submarine "lung." Nervous stability is important, as a special nervous strain results from this type of work. Much study has been devoted to the vitiation of air which follows from respiration during submergence. The upper permissible limit for carbon dioxide is 3 per cent and the lower limit for oxygen 17 per cent, both of these including a margin of safety. Lethal or toxic gases have caused serious accidents: If sea water gains access to the storage batteries, sodium chloride will be electrolized and chlorine evolved in dangerous volume. Another highly toxic gas which has led to poisoning is arsine, or arseniuretted hydrogen. Methyl chloride has also been known to produce dangerous poisoning in submarines. Besides gases, high temperatures and high humidities, especially under certain circumstances, produce serious problems during submerged operation. Numerous safety devices have been developed to counteract such hazards, including an analyzer to determine the concentration of carbon dioxide in the air and most notably the escape appliance better known as the submarine "lung" and designed for individual escape from the submarine. Finally, the special strain which submarine duty imposes on the personnel requires suitable facilities at the home base for comfort, relaxation and frequent leave periods.—*Jour. A.M.A.*, 116:235, (Jan. 18) 1941.

†Brown, Capt. E. W.: The human mechanism and the submarine. U. S. Naval Institute Proceedings, 66:1608, (Nov.) 1940.

Woman's Auxiliary

WHY READ THE BULLETIN?

(Prepared by Special Request)

By Mrs. V. E. Holcombe
President of Woman's Auxiliary to American Medical Association
Charleston, W. Va.

* * * For those of you who possibly may not be entirely up-to-date, I might just mention the *Bulletin* is merely the new name which has been given to the publication that was formerly called the News Letter. It is an attractive little booklet, issued quarterly—price $1.00 per year. It is published for the express purpose of furthering our fellowship, and propagating the principles and ideals of our organization. Advancement in any organization is in direct relationship to the improvement of facilities for the exchange and interchange of facts, information, knowledge and truth, and the proper use of those facilities.

* * * There are so many worthwhile happenings in the medical world of today, which are interesting to know, even if they are never used. With the questionable and critical attitudes toward the medical profession which have arisen in the past few years, it is important that we "pool our assets" and present a united front to adverse forces and influences.

Dr. Parran, Chief of the U. S. Health Service, says that last year was the "healthiest" year in the history of the United States; viz: the death rate was lowest per capita. In spite of all "drives" and scares and tales of neglect, the United States is the healthiest country in the civilized world.

Even the most bureaucratic-minded and garrulous must give the medical men of the world the credit for this condition. Increasing the span of life from thirty-seven years to sixty-five years in less than a century was not accomplished by law-makers.

* * * The immediate goal of our auxiliary is to increase the circulation of the *Bulletin* to include at least one-fourth of our Auxiliary membership. That means that we should have approximately 6,000 readers. It means that *your* Auxiliary must send at least one-fourth of *your* membership. * * *

Ingham County

The Woman's Auxiliary to the Ingham County Medical Society opened the new season with a tea at the home of Mrs. W. H. Welch in East Lansing. We had the pleasure of hearing Mrs. Roger V. Walker of Detroit, our State President, discuss the plans of the State Auxiliary for the year. Other state officers present were Mrs. William Butler of Grand Rapids, Mrs. Oscar Stryker of Fremont, and Mrs. A. O. Brown of Detroit. We also issued invitations to the members of the Ionia, Montcalm, Shiawassee and Eaton County auxiliaries. At the meeting we pledged our support to the National Red Cross drive during which our members made the house to house canvass and operated booths in prominent places of business through the entire week.

Annually in November we entertain the members of the Ingham County Medical Society with a Bohemian feast which precedes the yearly Keno party of the society. This is an event that we have enjoyed for

several years and receives most enthusiastic support from all of us.

In December, we met at Mrs. D. A. Gailbraith's home and received the greatest incentive possible for the Christmas season from a program in the true Christmas tradition, consisting of old Welch and English carols and readings. At this meeting we completed our plans for gifts and Christmas trees for the Contagious Hospital and the Lansing Children's Home which is an annual custom with us.

Our January meeting promises to be one of unusual interest. Our capable program chairman, Mrs. Robert Breakey, has secured for a speaker a foreign traveler caught on a remote South Sea Island for many months due to the interruption of shipping after the outbreak of war, and we anticipate a large attendance.

—Mrs. C. S. Davenport, *Secretary*

Ionia-Montcalm

The Woman's Auxiliary of the Ionia-Montcalm County Medical Society had dinner with the Medical Society at Winter Inn, Greenville, Tuesday, December 10. After dinner, members of the Auxiliary went to the home of Dr. and Mrs. W. L. Bird. Mrs. Kling called the meeting to order with nine members present. Mrs. Kling gave a report about her trip to the Mid-year Board Meeting. Mrs. Eichelberg, Greenville school nurse, gave an instructive talk on health work being done in the schools of Greenville, emphasizing the work on inspection to guard against communicable diseases.

—Mrs. M. A. Hoffs, *Secretary*

Kent County

The Woman's Auxiliary to the Kent County Medical Society met December 11 in the auditorium of the Public Museum. Mrs. Guy De Boer, president, presided at the business meeting. Dr. V. M. Moore spoke on "State Controlled Medicine." He showed how Michigan's answer to State Medicine has been the "Michigan Medical Service," a corporation which sells medical insurance to employed groups of twenty-five or more in the low income group.

—Wilamina Winter, *Press Chairman*

Kalamazoo County

The Kalamazoo Auxiliary was entertained by the Academy of Medicine at the Burdick Hotel, Tuesday evening, December 16.

George E. Bushnell, Chief Justice of the Supreme Court of Michigan, spoke on "The Mechanics of the Supreme Court."

Members of the Auxiliary brought home-made candy and gifts to be given the Aged People at Christmas time. There were ninety-eight in attendance.

—(Mrs. Gerald H.) Frances Rigterink,
Publicity Chairman

Monroe County

The Auxiliary to the Monroe County Medical Society met at the home of Mrs. William W. Bond on November 18, 1940. After a business meeting the members sewed for the Red Cross. Later refreshments were served by Mrs. Bond and Mrs. L. C. Blakey, joint hostesses.

The Auxiliary met at the home of Mrs. Wm. Acker, December 4, 1940. After the business meeting the members sewed for the Red Cross and refreshments were served by Mrs. Acker and Mrs. J. J. Siffer, joint hostesses.

—Mrs. A. H. Reisig, *Press Chairman*

MICHIGAN'S DEPARTMENT OF HEALTH

HENRY A. MOYER, M.D., Commissioner, Lansing, Michigan

MIDWINTER JOINT MEETING

For the second time, a midwinter meeting of health officers and secretaries of county medical societies was held in January. The health officers held a two-day session January 18 and 19 in the Hotel Olds, and the joint session began with a 1 o'clock luncheon, January 19. P. R. Urmston, M.D., president of the Michigan State Medical Society presided at the meeting. H. Allen Moyer, M.D., State Health Commissioner, led brief discussions at the close of each of four ten-minute papers. The four talks were on industrial health, immunization for babies and children, tuberculosis case finding and the five-day treatment for syphilis.

NEW PNEUMONIA SERUM AVAILABLE

Pneumonia serum produced by an improved method of refinement developed in the Michigan Department of health laboratories is now available in all 47 of the typing centers stocking state serum. This serum is available for types 1, 2, 5, 7 and 8 pneumonia.

STATE MONEY NEEDED

State funds will be requested of the legislature for three current activities of the Michigan Department of Health which are now supported by federal grants. The three and the amounts to be requested are: Industrial hygiene, $35,000 annually for the fiscal years ending June 30, 1942, and 1943; resort and rural sanitation, $25,000 a year; and venereal disease control, $40,000 a year. The first and third activities are connected with national defense production and with military training.

MEASLES CASES DOUBLE

Half the counties of the state are now reporting measles in a rise of cases which undoubtedly is preliminary to an epidemic in the next few months.

Reported cases in December were double those of November, and November cases were three times those of October. The figures for the three months are: October 659, November 1,711, December 3,455. Total for the year is 19,998.

Eighty-thousand case epidemics occurred in 1935 and 1938, and presumably 1941 will be another big year. The 1940 cases reported, however, were more than three times the cases reported in the years leading up to the 1935 and 1938 epidemics.

"FLU" NOT REPORTED

Case reports reaching the State Health Department have not yet reflected the prevalence of influenza which is epidemic in a mild form in some parts of the state. Influenza was formerly reportable only in epidemics, but it was made reportable generally in 1939. In that year 2,288 cases were reported. In 1940, 378 cases were reported, 28 cases in November and 32 cases in December.

SHIAWASSEE

The new county health unit in Shiawassee County started operation January 1. The director is Dr. T. E. Camper, formerly director of the Iron County Health Department. Offices of the unit are in the courthouse at Corunna. Temporarily, until Dr. Camper completes some special work at the University of Michigan, the office is in charge of Dr. E. V. Thiehoff, assistant director of the Bureau of Local Health Services. Shiawassee is the sixty-third county to establish full-time public health service.

MARKED DECREASE IN SMALLPOX

Smallpox cases reported in 1939 totaled 371, the highest annual figure in seven years. In 1940, the number of reported cases dropped below 100 for the first time since 1936, the total being 78. Nearly half of the 1940 cases were reported in the last two months of the year when 21 cases were reported in November and December from Highland Park and 15 for the two months from Detroit.

CRIPPLED CHILDREN*

. . . According to reliable figures there are 7,000 crippled and more than 20,000 afflicted children in Michigan who need immediate care. Economic and medical investigations show that they must look to their state government for urgently needed medical help—yes, they are looking to us during this session of the Legislature hoping their prayers will not be denied.

I urge this Legislature to take immediate action to provide needed funds to assist these children. I am advised that these funds may have to take the form of a deficiency appropriation. I do not hesitate to recommend such a course.

It is sound economy to rehabilitate these helpless young people, through medical care or hospitalization, so they may become useful and self-supporting members of society. Neglected they will remain permanent state charges.

During the lifetime of the Crippled Children's Commission since 1927, some 8,000 children have had physical deficiencies corrected, and have been given vocational training. Latest reports show that they are earning an average of $18.35 per week, and their total yearly income is $7,008,000.

Experience of the last two years has proved that the formula now used for distributing this type of state aid is cruelly unjust. This formula specifies that 75 per cent of the funds shall be distributed to the counties on the basis of population and 25 per cent on the basis of need. Monthly expenditures by the counties are budgeted in advance and set at a fixed sum.

The fallacies of this plan were accentuated by the severe outbreak of infantile paralysis in 1940, which struck concentrated blows in many counties, while others escaped with only a few cases. Moreover, the disease wrought its worst havoc in several cases in counties least able to pay.

To correct this unjust and inequitable condition, I call to your attention the necessity for amending Act No. 283, Public Acts of 1939, so that appropriations for crippled and afflicted children will be distributed solely on the basis of need. This is recommended by those familiar with this problem and I cannot urge you too strongly to give favorable consideration to this revision.

The Act should be further revised to simplify its language eliminating all detailed provisions which make it difficult to administer and which properly should be left to the discretion of the Commission. These revisions would be helpful in bringing additional Federal funds to Michigan for this important part of our social program.

Formation of committees to provide medical and economic filters to coöperate with judges of probate is considered a progressive step. Every necessary measure must be taken to improve the administration of this Act.

*Message to the Legislature by Gov. Murray D. Van Wagoner, reprinted from the *Journal of the House of Representatives of Michigan*, Session of 1941, Journal Number II.

COUNTY AND PERSONAL ACTIVITIES

President P. R. Urmston announces the appointment of Edgar H. Norris, M.D., and Ralph H. Pino, M.D., Detroit, to the Postgraduate Medical Education Committee of the State Society.

* * *

The Northern Tri-State Medical Association will hold its 1941 meeting in Tiffin, Ohio, on April 8. Further announcement and program will appear in the March issue of THE JOURNAL.

* * *

Robert S. Breakey, M.D., Lansing, addressed the Shiawassee County Medical Society in Owosso on Thursday, January 16, on the subject "Modern Urology, Diagnosis and Treatment."

* * *

Reed M. Nesbit, M.D., and *Rigdon K. Ratliff, M.D.,* Ann Arbor, are the co-authors of "Hypertension Associated with Unilateral Renal Disease" which appeared in *The Journal of the American Medical Association,* issue of January 18, 1941.

* * *

St. Mary's Hospital, Detroit, will hold its annual Clinic Day on March 20. The conferences will be presided over by Frederick Coller, M.D., Ann Arbor; C. G. Johnston, M.D., J. P. Pratt, M.D., Detroit, and other outstanding medical men.

* * *

Martha Longstreet, M.D., Saginaw, was recently chosen by the Saginaw Board of Commerce as the "outstanding Saginaw citizen of the year," the first woman to receive the honor in the history of the award which was first given in 1922. Congratulations, Doctor Longstreet!

* * *

Leo M. Ford, J.D., author of the article "Keeping Complete Written Records" which appeared in the January, MSMS JOURNAL, is attorney for the Medical Protective Company of Fort Wayne, Indiana. This article was third in a series of authoritative discussions on medical problems written by Mr. Ford for the MSMS JOURNAL.

* * *

The Radio Committee of the MSMS advises that the following Health Talks were broadcast over radio station CKLW:

Saturday, January 11, 1941—"Diabetes" by Geo. C. Thosteson, M.D., Detroit
Saturday, January 18, 1941—"Relationship of Dentistry and Medicine" by Horton D. Kimball, D.D.S., Detroit
Saturday, January 25, 1941—"Artificial Fever Therapy" by Donald Francis, M.D., Detroit

The Van Meter Prize Award is offered by the American Association for the Study of Goiter, consisting of $300 and two honorable mentions for the best essays submitted concerning original work on problems related to the thyroid gland. The essays may cover either clinical or research investigations, should not exceed 3,000 words, should be typewritten, double spaced, and sent to Dr. W. Blair Mosser, 133 Biddle Street, Kane, Pennsylvania, not later than April 1, 1941.

* * *

The International College of Surgeons will hold its Fifth International Assembly in Mexico City, August 10 to 14, 1941. Surgeons in the United States desiring information about the presentation of papers or scientific exhibits are requested to write Dr. Desiderio Roman, Chairman of the Scientific Committee, 250 S. 17th Street, Philadelphia. For travel information, communicate with Dr. Max Thorek, 850 W. Irving Park Blvd., Chicago.

* * *

Doctor, remember your particular friends, the exhibitors, at your annual convention, when you have need of equipment, appliances, medical supplies, and service. Here are ten more of the firms which helped make the 1940 convention such a success:

Petrolagar Laboratories, Inc., Chicago
Pet Milk Sales Corporation, St. Louis
The Pelton & Crane Company, Detroit
Parke, Davis & Company, Detroit
The Muller Laboratories, Baltimore
C. V. Mosby Company, St. Louis
Michigan Medical Service-Michigan Hospital Service, Detroit
The Wm. S. Merrell Company, Cincinnati
Merck & Company, Inc., Rahway, New Jersey
The Mennen Company, Newark, New Jersey

* * *

The Council of the Wayne County Medical Society approved the recommendation of the Military Affairs Committee that a Medical Mobilization Committee be appointed to make surveys and plans for any eventuality in case of a national emergency. The Military Affairs Committee stressed the fact that Detroit is the center of the National Rearmament program and there is more likelihood of sabotage in the large industrial establishments, which if struck by fire or explosion would tax the facilities existing for medical care of those who might be wounded. In case of war, Detroit would be one of the first targets of the enemy's bombing planes. The Mobilization Committee is to study plans for rapid mobilization of the medical forces, as well as the obtaining of supplies, the care of the injured, education of the public with regard to public health problems which air raids or other catastrophes might bring and other problems of medical mobilization.

* * *

The Selective Service Headquarters, Washington, D. C., recently announced the appointment of Leonard G. Rowntree, M.D., as Chief of the Medical Division of the Selective Service System with the rank of Colonel of the Medical Corps.

In announcing the appointment of Dr. Rowntree, C. A. Dykstra, the Director of Selective Service, said, "We are fortunate to have such an experienced executive and widely known medical authority in charge of this significant phase of the Selective Service program. Dr. Rowntree's work at Johns Hopkins Hospital and the Mayo Clinic, and his service in France during the

World War of 1917, make him highly qualified for his difficult duties." Thus one of the most prominent medical men in the United States and a veteran of the World War is again in active service heading the medical profession of this country in making its contribution to National Defense.

* * *

COUNCIL AND COMMITTEE MEETINGS

1. *Sunday, December 29, 1940.*—3:00 p. m.—Special Committee on NYA Health Program, Hotel Olds, Lansing.
2. *Monday, January 6, 1941*—6:30 p. m.—Cancer Committee—Woman's League Bldg., Ann Arbor.
3. *Wednesday, January 8, 1941*—6:00 p. m.—Insurance Drafting Committee—Hotel Statler, Detroit.
4. *Thursday, January 9, 1941*—6:00 p. m.—Preventive Medicine Committee—Wardell Hotel, Detroit.
5. *Thursday, January 16, 1941*—5:30 p. m.—Mental Hygiene Committee—Eloise Hospital, Eloise.
6. *Sunday, January 19, 1941*—3:00 p. m.—Syphilis Control Committee—Hotel Olds, Lansing.
7. *Sunday, January 19, 1941*—4:30 p. m.—Afflicted Child Committee—Hotel Olds, Lansing.
8. *Friday, January 24, 1941*—12:00 noon—Maternal Health Committee—Hotel Statler, Detroit.
9. *Wednesday, January 29, 1941*—12:15 p. m.—Postgraduate Medical Education Committee—University Hospital, Ann Arbor.

* * *

COUNTY MEDICAL SOCIETY MEETINGS

Allegan—Tuesday, December 3, 1940—Allegan Health Center, Allegan—Annual Meeting—Election of Officers.

Alpena-Alcona-Presque Isle—Thursday, December 19, 1940—Annual Meeting, Election of Officers.

Bay-Arenac-Iosco—Wednesday, January 15, 1941—Bay City—Speaker: Donald C. Beaver, M.D., Detroit. Subject: "Gynecological Pathology."

Calhoun—Tuesday, January 7, 1941—Battle Creek—Speaker: Norman Miller, M.D., Ann Arbor. Subject: "Obstetric and Gynecologic Problems."

Delta-Schoolcraft—Wednesday, December 4, 1940—Escanaba—Annual Meeting, Election of Officers.

Dickinson-Iron—Thursday, January 2, 1941—Iron Mountain—Speakers: Drs. Boyce, Smith and Andersen.

Grand Traverse-Leelanau-Benzie—Tuesday, December 3, 1940—Annual Meeting, Election of Officers—Speakers: Frank Bethel, M.D., and John Sheldon, M.D., Ann Arbor.

Hillsdale—Thursday, January 16, 1941—Jackson—Met with other socities of Second Councilor District.

Ingham—Tuesday, January 21, 1941—Lansing—Annual President's Dinner—Speaker: Mr. John Bugas, Director of the Federal Bureau of Investigation for the Michigan District.

Jackson—Thursday, January 16, 1941—Jackson—Host to Second Councilor District Meeting.

Kalamazoo—Tuesday, January 21, 1941—Kalamazoo—Speaker: Frederick Coller, M.D., Ann Arbor. Subject: "Surgical Treatment of Peptic Ulcer."

Kent—Tuesday, January 14, 1941—Grand Rapids—Program: "Studies in Human Fertility."

Manistee—Monday, December 23, 1940—Manistee—Annual Meeting—Election of officers.

Muskegon—Friday, January 17, 1941—Muskegon—Gonadogen Sound Film.

Medical Society of North Central Counties—Wednesday, December 18, 1940—Roscommon—Annual Meeting, Election of Officers.

Oakland—Wednesday, January 8, 1941—Rotunda Inn, Pine Lake—Host to 15th Councilor District Meeting.

Ottawa—Friday, January 10, 1941—Grand Haven—Speaker: Florian E. Schmidt, M.D., showed film on "Post-Encephaletic Parkinsonism with Bella-Bulgarian Treatment."

Tuesday, January 14, 1941—Holland—Speaker: T. E. Gibson, M.D., Lansing—Subject: "Venereal Diseases."

St. Clair—Tuesday, January 14, 1941—Port Huron—Speaker: Luther Leader, M.D., Detroit—Subject: "Surgical Lesions of the Colon."

St. Joseph—Thursday, January 9, 1941—Three Rivers—Speaker: Langdon Crane, M.D., Highland Park—Subject: "Newer Treatments of Pneumonia."

Thursday, February 13, 1941—Sturgis—Speaker: Warren E. Wheeler, M.D., Lansing—Pediatric subject.

Shiawassee—Thursday, January 16, 1941—Owosso—Speaker: Robert S. Breakey, M.D., Lansing—Subject: "Diagnosis and Treatment in Modern Urology."

Washtenaw—Tuesday, January 14, 1941—Ann Arbor—Clinical Pathological Conference conducted by Carl V. Weller, M.D., Ann Arbor.

Wayne—Monday, January 13, 1941—Detroit—Speaker: Albert M. Snell, M.D., Rochester, Minnesota—Subject: "Some Recent Studies on Hepatic Disease."

Monday, January 20, Detroit—General Practice Meeting. Symposium on Pneumonia.

Monday, January 27—Detroit—Speaker: Gilbert Horax, M.D., Boston—Subject: "Neurosurgical Procedures for the Relief of Pain."

Monday, February 3 and 10—Detroit—Speaker: Armand Quick, M.D., Milwaukee Beaumont Lectures.

Monday, February 17—Detroit—Speaker: Ashley A. Weech, M.D., New York—Subject: "The Physical and Cerebral Developments of Normal Children."

Monday, February 24—Detroit—Speaker: James Barrett Brown, M.D., St. Louis—Subject: "Limitatoins and Possibilities in Reconstructive Surgery."

West Side (Wayne County)—Wednesday, January 15, 1941—Speaker: I. F. E. Schmidt, M.D., Chicago—Movie on Treatment of Pneumonia and on Treatment of Encephalitis.

* * *

NEW COUNTY MEDICAL SOCIETY OFFICERS

Alpena-Alcona-Presque Isle

President—H. J. Burkholder, M.D., Alpena
Vice President—E. A. Hier, M.D., Alpena
Secretary-Treasurer—Harold Kessler, M.D., Alpena
Delegate—W. E. Nesbitt, M.D., Alpena
Alternate Delegate—A. R. Miller, M.D., Harrisville

Barry

President—C. A. E. Lund, M.D., Middleville
Secretary—A. B. Gwinn, M.D., Hastings

Delta-Schoolcraft
President—Nathan J. Frenn, M.D., Bark River
Vice President—D. H. Boyce, M.D., Escanaba
2nd Vice President—A. R. Tucker, M.D., Manistique
Secretary-Treasurer—A. C. Bachus, M.D., Powers
Delegate—J. J. Walch, M.D., Escanaba
Alternate Delegate—W. A. LeMire, M.D., Escanaba
Medico-Legal Advisor—A. S. Kitchen, M.D., Escanaba

Jackson
President—A. M. Shaeffer, M.D., Jackson
President-Elect—L. L. Stewart, M.D., Jackson
Secretary—Horace Wray Porter, M.D., Jackson
Treasurer—John B. Holst, M.D., Jackson
Board of Directors—R. H. Alter, M.D., Jackson—term expires 1943
G. R. Bullen, M.D., Jackson—term expires 1942
J. D. VanSchoick, M.D., Hanover—term expires 1941

Kalamazoo
President—Charles L. Bennett, M.D., Kalamazoo
President-Elect—Homer Stryker, M.D., Kalamazoo
1st Vice President—Lawrence Banner, M.D., Kalamazoo
2nd Vice President—Maynard Southworth, M.D., Schoolcraft
3rd Vice President—Gerald Behan, M.D., Galesburg
Secretary—Hazel R. Prentice, M.D., Kalamazoo
Treasurer—Carl Wagar, M.D., Kalamazoo
Delegates—I. W. Brown, M.D., Kalamazoo—1941
Louis W. Gerstner, M.D., Kalamazoo—1942
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In Memoriam

A Testimony to Dr. J. G. Huizinga

We, the members of the Ottawa County Medical Association, realizing that in the passing of Dr. J. G. Huizinga we have lost a capable, highly respected member, do hereby testify that, as a colleague he was aggressive, but always honest and loyal to his profession; as a citizen, he was conservative, but always ready to help along in any worthy cause, and to support civic improvements; as a man, he stood fearlessly and courageously for what he thought was right, but always tolerant and reasonable.

We sincerely regret to miss him from our membership roll, but trust that we shall in the future as in the past, derive benefit from his having been one of us.

In token of our high regard for our departed colleague, we request our secretary to have this testimony published in our State JOURNAL, and to send a copy to the family and incorporate in our minutes.

Your committee,

A. LEENHOUTS, M.D., *Chairman*
O. VAN DER VELDE, M.D.
R. NICHOLS, M.D.

LETTER TO THE EDITOR

My dear Editor:

I thought possibly this small piece of work might be of interest to the general medical men as well as the Nose and Throat men.

This patient was operated upon by me for a tonsillectomy under local anesthetic and returned to her home in Detroit four or five days later. A slight cold was present before complete recovery and this article was sent as a result. I think this is rather clever and thought some of the other men might enjoy it too.

C. M. M.

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READING NOTICES

THREE-QUARTERS OF A CENTURY FOR PARKE, DAVIS & COMPANY

The year 1941 marks the Diamond Anniversary of the founding of Parke, Davis & Company, a firm which had its inception in a small drug store in the City of Detroit, Michigan, and which, during the past seventy-five years, has become the world's largest makers of pharmaceutical and biological products.

From the very beginning, back in 1866, Parke, Davis & Company has engaged in research work with the object of making available to pharmacists and physicians, medicinal preparations of the highest degree of accuracy.

In the early 70's, pharmaceutical progress meant the discovery of new vegetable drugs. Energetic—and extensive—explorations gave to the medical profession such valuable and widely used drugs as Cascara and Coca. Then, in 1879, came one of Park, Davis' greatest contributions to pharmacy and medicine— the introduction of the first chemically standardized extract known to pharmacy. Desiccated Thyroid Gland, the first endocrine product supplied by the Company, was introduced in 1893. One year later, Parke, Davis established the first commercial biological laboratory in the United States. In 1897 came the introduction of the first physiologically assayed and standardized extracts. And throughout these early years, the fundamental Parke, Davis policy—precision in pharmaceutical manufacture—was crystallizing.

Since the turn of the century, progress of the Company has continued apace. An aggressive program of research has been zealously pursued, marked by the introduction of many important medicinal products. Diversified research activities cover the major phases of medical treatment—including the endocrine, biological, vitamin, and chemotherapeutic—and new discoveries are carefully evaluated through the Company's extensive facilities for clinical investigation.

The Company's home offices and research and manufacturing laboratories in Detroit occupy six city blocks on the Detroit Riverfront, adjacent to the Detroit-Walkerville ferry, which connects the City of Detroit with the Province of Ontario, Canada.

A beautiful farm of 700 acres, known as Parkedale and located near Rochester, Michigan, about thirty miles from Detroit, is utilized for the production of antitoxins, serums and vaccines, and for the cultivation of medicinal plants.

In addition to its Detroit headquarters, branches and depots are maintained in important cities throughout this country, and the world.

STATUS OF THE MEAD JOHNSON VITAMIN A AWARD

Meeting in New York, June 4, 1937, the Judges stated that the presentation of the Award "at this time is not warranted since no clinical investigation on vitamin A has yet been published which completely answers any of the objectives of the original proposal. The Judges, therefore, agreed to defer further consideration of the granting of this award until December 31, 1939. This action was taken because of the existence of pronounced differences of opinion among investigators as to the reliability of any method yet proposed for determining the actual vitamin A requirements."

On November 19, 1940, the Judges met at Memphis and stated that "considerable progress in research with vitamin A has been made, principally along two main lines of endeavor. The fields showing most promise are those involving dark adaptation and blood serum studies. The Judges feel that there is still too much

uncertainty about the relative merits of several investigations to warrant making the award at this time. It was, therefore, agreed that the giving of the award be postponed until clear resolution of various factors is achieved."

The sum of $15,000, called for by the Main Award, remains as a cash deposit in escrow with the Continental Illinois National Bank and Trust Company of Chicago, and will be paid immediately upon official notification of the Judges' decision.

The Judges are: Isaac A. Abt, Chicago; K. D. Blackfan, Boston; Alan Brown, Toronto, Canada; Horton R. Casparis, Nashville; S. W. Clausen, Rochester, N. Y.; H. F. Helmholz, Rochester, Minn.; E. V. McCollum, Baltimore; L. T. Royster, Charlottesville, Virginia; Robert A. Strong, New Orleans, La.

THE DOCTOR'S LIBRARY

Acknowledgement of all books received will be made in this column and this will be deemed by us as a full compensation of those sending them. A selection will be made for review, as expedient.

CLINICAL PELLAGRA. By Seale Harris, M.D., Professor Emeritus of Medicine, University of Alabama, Birmingham, Alabama. Assisted by Seale Harris, Jr., M.D., formerly Assistant Professor of Medicine, Vanderbilt University, Birmingham, Alabama. With foreword by E. V. McCollum, Ph.D., Sc.D., LL.D., Professor of Biochemistry, School of Hygiene and Public Health, The Johns Hopkins University, Baltimore, Maryland. Illustrated. St. Louis: The C. V. Mosby Company, 1941. Price: $7.00.

The increased interest in vitamin deficiencies makes this study, that of the earliest of American deficiency diseases, of great value. While its primary importance is, of course, to the physicians of the South, sufficient sub-clinical pellagra is seen by the northern physician to make this monograph well worth while. McCollum says, "The title hardly does justice to the book. It is a philosophic treatment of clinical and experimental data of many kinds, interpreted by many able workers who contributed to the development of our knowledge of the biochemistry of nutrition * * * ."

METHODS OF TREATMENT. By Logan Clendening, M.D., Clinical Professor of Medicine, Medical Department of the University of Kansas; Attending Physician, University of Kansas Hospitals; and Edward H. Hashinger, A.B., M.D., Clinical Professor of Medicine, Medical Department of the University of Kansas; Attending Physician, University of Kansas Hospitals; Attending Physician, St. Luke's Hospital, Kansas City, Mo. With chapters on special subjects by J. B. Cowherd, M.D.; Leland F. Glaser, M.D., Thomas B. Hall, M.D.; John S. Knight, M.D.; H. P. Kuhn, M.D.; Paul H. Lorhan, M.D.; F. C. Neff, M.D.; Don Carlos Peete, M.D.; Carl O. Rickter, M.G.; E. H. Skinner, M.D.; O. R. Withers, M.D.; and Lawrence E. Wood, M.D. Seventh Edition. St. Louis: The C. V. Mosby Company, 1941. Price: $10.00.

This is the seventh edition of a book first published in 1924. In this edition new sections have been added on the uses of sulfanilamide, backaches, peripheral vascular diseases, deficiency diseases and anesthetics. Clendening's manner of considering the history and general conception of the disease in a very condensed

form and then following by describing the treatment in detail with the results which the physician may expect, makes the volume very desirable to any practitioner of medicine. Discussions are concise and yet completely sufficient.

THE 1940 YEAR BOOK OF INDUSTRIAL AND ORTHOPEDIC SURGERY. Edited by Charles F. Painter, M.D., Orthopedic Surgeon to the Massachusetts Women's Hospital and Beth Israel Hospital, Boston. Chicago: The Year Book Publishers, Inc., 1940. Price: $3.00.

This is a 484-page review of the late literature on traumatic surgery and orthopedic procedures. A symposium on arthritis is the highlight and really worth reading. The present interest in traumatic surgery due to the war makes this Year Book of interest to many surgeons.

FOREIGN BODIES LEFT IN THE ABDOMEN. The Surgical Problems—Cases, Treatment, Prevention. The Legal Problems—Cases, Decisions, Responsibilities. By Harry Sturgeon Crossen, M.D., School of Medicine, Washington University; and David Frederic Crossen, LL.B., School of Law, Washington University, St. Louis, Mo. With 212 illustrations including 4 color plates. St. Louis: The C. V. Mosby Company, 1940. Price: $10.00.

The Crossens have combined, to include in one volume, the surgical problems and the legal problems. There is probably no surgeon who at one time or another has not either left a foreign body in the abdomen or feared that he has. For that reason this very inclusive book is of great value to any surgeon. It is indispensable to the surgeon or roentgenologist.

THE 1940 YEAR BOOK OF PATHOLOGY AND IMMUNOLOGY. Pathology edited by Howard T. Karsner, M.D., Professor of Pathology, Director of the Institute of Pathology, Western Reserve University, Cleveland. Immunology edited by Sanford B. Hooker, A.M., M.D., Professor of Immunology, Boston University School of Medicine; Member, Evans Memorial for Clinical Research and Preventive Medicine; Immunologist, Massachusetts Memorial Hospitals. Chicago: The Year Book Publishers, Inc., 1940. Price: $3.00.

This is the first year book for the laboratory physician and reviews the current literature for this group as well as for other specialists who are interested in the new developments of the fundamental sciences relating to their specialties. Sanford B. Hooker is one of the pioneers of immunology and his concise pointed comments are most practical.

"The function of this Committee is to control, in so far as is possible, those conditions that are sources of inefficiency and losses of time which arise out of ill health," Dr. Selby stated at the first meeting of the Industrial Medicine Subcommittee of the Council of National Defense held recently at the United States Public Health Service.

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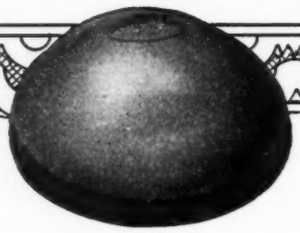

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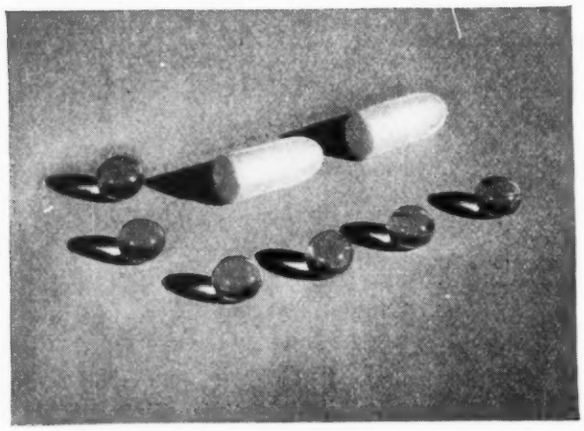

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[1] Sevringhaus, E. L., and Evans, J. S.: *Am. J. M. Sc.* 178:638, Nov. 1929.
[2] Novak, Emil: *Surg. Gynec. & Obst.* 70:124, Jan. 1940.

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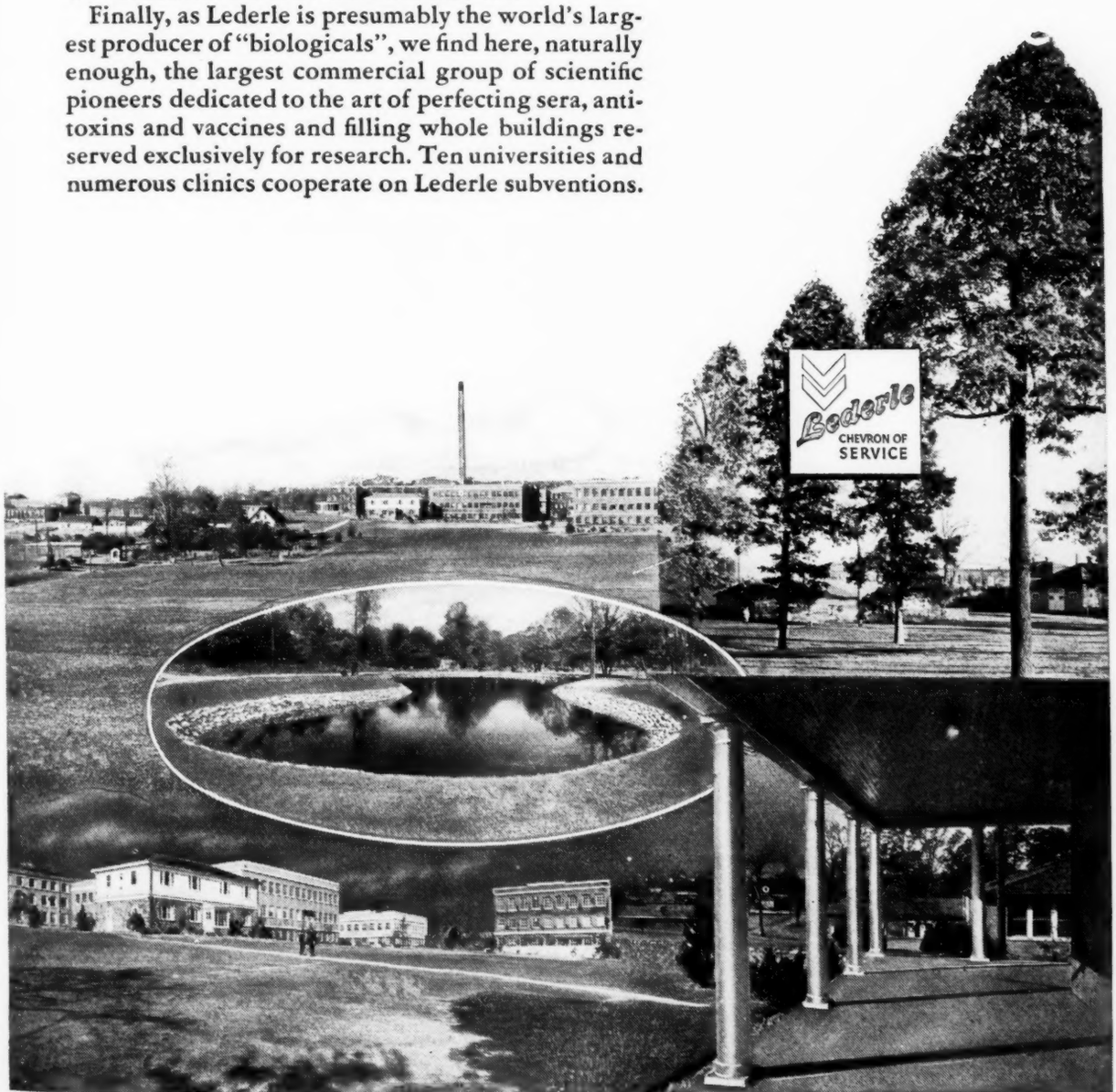

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